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ABSTRACT

Originally developed to respond to the Desert Storm/Persian Gulf War, this resource book provides information designed to help parents, teachers, and service providers to plan and implement a comprehensive response to meeting children's emotional needs during a crisis. Contributors are experts on different kinds of crises that school age children typically face. Papers included are: (1) "Crisis Counseling in the Schools" (Jonathan Sandoval); (2) "Crisis Counseling: Conceptualizations and General Principles" (Jonathan Sandoval); (3) "Best Practices in Crisis Intervention" (Valerie Smead); (4) "Best Practices in Crisis Intervention" (Scott Poland and Gayle Pitcher); (5) "Crisis Response Teams: A Must for All School Districts" (Al Neuhaus); (6) "Crisis Teams Can Minimize Traumatic Events" (from "Spotlight," Newsletter of the Los Angeles School District); (7) "Role of the School Psychologist in Confronting Crisis" (Stewart Ehly); (8) "Child Psychiatrists Describe Children's Reactions to Disaster" (summary of an article in the "Journal of the American Academy of Child Psychiatry"); (9) "Bereaved Children Speak" (Dorothy Vacca); (10) "Children and Anxiety" (Thomas Huberty); (11) "Children and Reactions to Death" (Charles Heath); (12) "Physical, Emotional and Behavioral Reactions to Crises" (B. Q. Haffen and B. Peterson); (13) "Reactions to Crises: Developmental Differences" (Scott Poland); (14) "Children and Responses to Desert Storm: Teacher Handout" (Debby Waddell and Alex Thomas); (15) "School's Response to Death, Suicide and Loss" (Peter Sheras); (16) "What to Say When Someone Dies" (Ann Mueller); (17) "Children in Crisis: Stress and Coping" (Stewart Ehly); (18) "Tips for Teachers in Dealing with Crises" (Scott Poland); (19) "Children's Response to Crisis: A Developmental Perspective" (Margaret Dawson); (20) "Responses to Children and Adolescents: Developmental Perspectives" (Scott Poland); (21) "Children and Responses to Desert Storm: A Parent Handout" (Debby Waddell and Alex Thomas); (22) "Parents' Responses to Children" (Scott Poland); (23) "Effects of Trauma Still a Part of Everyone's Life" (Betty Spicher); (24) "Effects Last Even When Sun Shines" (Jan Harlsom); (25) "Winnetka: One Year Later" (Harry Dillard); (26) "Early Intervention in a Disaster: The Cokeville Hostage/Bombing Crisis" (Nohl Sandall); (27) "Impressions of the Bay Area Quake" (Betty Spicher); (28) "Cross Cultural Issues in Responding to a Tragedy: The Stockton Schoolyard Shootings" (Mike Armstrong); and (29) "Disaster Team Works During Crisis" (Gary Aderman). (NB)

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School, Family and Community Applications

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For the 21st Century...

We will need to understand how societal influences external to schools impact on the job schools do. We will need to take what is unique about growing up in the late 20th century and combine it with what is immutable about children's patterns of development and learning.

Margaret M. Dawson
NASP President

Howard M. Knoff
NASP Immediate Past-President

The programs and activities of the National Association of School Psychologists (NASP) seek to advance the field of school psychology, the professional growth of NASP members, and the interests of children and youth are served by school psychologists throughout the United States and overseas. Founded in 1969, NASP now has a membership of 16,000.

The purposes of NASP are, through research, education and advocacy, to:

- Serve the mental health and educational needs of all children and youth.
- Encourage and provide opportunities for the professional growth of individual members.
- Inform the public about the services and practice of psychology in the schools.
- Advance the standards of the profession of school psychology.

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January 1991

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RESOURCES IN CRISIS INTERVENTION: SCHOOL, FAMILY AND COMMUNITY APPLICATIONS

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PREFACE

It is no wonder that our children and youth are worried. For the first time in human history, our advanced technology has made us all a part of a war. Desert Storm is not a remote phenomenon that we just hear or read about. We see events on television as they unfold. We know about the potentialities of environmental havoc from oil spills in the Persian Gulf and the effects chemical warfare can have. We learn that terrorism may occur within our own country. And mothers and fathers who are our neighbors and friends are now in Saudi Arabia, sending greetings to us via television satellite hook-ups.

For some American children and youth, Operation Desert Storm has had an even greater immediate impact. The current (January, 1991) situation in the Middle East has resulted in the deployment of significant numbers of military personnel from Department of Defense installations around the world. Over 150,000 American children of these military personnel are attending Department of Defense Dependents Schools (DoDDS). In the United States, many schools located near military bases have large numbers of students with parents or relatives who are involved in Operation Desert Storm.

The gravity and uncertainty of war has created a need to implement mental health support services to the children and families of military personnel in the United States and abroad and to the larger community of families that are directly or indirectly impacted by Operation Desert Storm. Such services are intended to supplement the variety of support systems available to children and their families through their schools and communities.

This time of crisis suggests the need for greater involvement of parents, teachers and community members to identify and meet the needs of children and youth who are experiencing the impact of Operation Desert Storm. The purpose of this resource book is to provide parents, teachers, family members and community-based service providers with information to help plan and implement a comprehensive response to meeting children's emotional needs.

The National Association of School Psychologists is currently working with the Department of Defense Dependents Schools to initiate a cross-disciplinary (school psychology, social work and counseling) project to assist DoDDS mental health staff and teachers to respond to children and families during this crisis. As part of this effort, NASP has compiled a number of resource materials of immediate use to human service workers, educators, and all others concerned with the impact of Operation Desert Storm on American children and youth.

The resource book is organized to provide interested readers with background information about crisis intervention and reactions to crises (Sections I and III), identifying children in crisis (Section IV) and how parents and professionals can respond effectively (Section V). Section II focuses on the roles that professional mental health workers can assume. Section VI deals with long-term effects and methods of follow-up.

All articles included in this resource book have been compiled from publications of the National Association of School Psychologists and/or made available to NASP by its members.

The National Association of School Psychologists is pleased to make available this resource book at a time when all human service professionals, educators, parents and concerned citizens are seeking ways to effectively address the questions, fears, and reactions of our nation's children and youth to war. Among its priorities, NASP is committed to:

- Championing the essential rights and welfare of all children and youth.

- Developing and promoting effective interventions which address distressing circumstances that impede the success and happiness of children and youth.

- Establishing working relationships with other professional organizations, individuals and groups that enhance educational and social-emotional outcomes for all children and youth.

- Vigorously advocate comprehensive services for all children and youth to meet their diverse needs.

This resource book is part of our mission. We are deeply concerned about our children and youth and share in the desire to provide the most effective mental health services to help them through these troubled times.

GUEST EDITOR'S COMMENTS:

CRISIS COUNSELING IN THE SCHOOLS

This mini-series is based on the view that the most legitimate counseling role for the school psychologist is that of crisis counselor. Crisis counseling and intervention are service activities sanctioned by schools. Such activities are consistent with a generally accepted preventative model of school psychological services, and fit the time constraints and demands placed on school psychologists. The need for this issue of *School Psychology Review* comes from the fact that information on general and specific theories and techniques of crisis counseling have not been collected together explicitly for school psychologists. Also it is not clear where school psychologists stand on counseling.

Most school psychologists list counseling with children and families as important duties they perform. Surveys of how school psychologists spend their time, however, indicate that assessment and assessment-related activities occupy the vast majority of psychologists' hours spent on the job. (Carroll, Harris & Bretzing, 1979; Cook & Patterson, 1977; Lacayo, Sherwood & Morris, 1981). It is clear that psychologists, though they value the activity, may not have a great deal of time for counseling because of the demands of other duties, and the current funding for special education which is interpreted to restrict them to 94-142 activities.

Besides the pressure of other activities, there are additional reasons school psychologists may not do much counseling. First, there are others in the school, guidance counselors and even social workers, whose job it is to do counseling. It is my experience, however, that the counseling done by counselors is most often centered around discipline and attendance issues and around educational and vocational decision making. They do not do much adjustment counseling and there is some question as to whether or not they are well enough trained to do long-term, mental health oriented psychotherapy. Although counselors work at the high school level, few exist in the elementary schools.

Another reason why school psychologists may not do much counseling is that they, too, are not well trained in this area. Weak preparation for the role may force them to stay away from counseling. This issue will provide much needed information. Most school psychologists certainly have a strong foundation onto which to build these crises counseling skills.

Some school psychologists would argue that counseling, particularly adjustment, mental health, or personality-reorganization counseling, has no place in the schools. These activities should go on outside of school settings, and should not be funded with educational monies. Only those efforts directly related to education (narrowly defined) have a place in the schools. These critics maintain that school psychologists should not do long term or even brief psychotherapy for they do not have institutional permission to do so.

In spite of the possible limited sanction for counseling, crises, by their very nature, do demand immediate intervention where they are encountered, and crises are frequently encountered in schools. Crises cannot be ignored. There may be time to refer other kinds of problems on to community agencies, but each hour of delay and organization in a time of crisis may require weeks of therapeutic time to repair. Because of the time imperative, crisis counseling is difficult to remove from the school's responsibilities.

Among the models of school psychological services delivery (Sandoval, in press), the prevention-promotion model is attractive because it suggests a wide range of activities for school psychologists to serve both children and adults, and both regular and special education populations. Crisis counseling and crisis intervention strategies mesh well with the model for they may be directed at primary, secondary, or tertiary prevention (Bower, 1964). Traditional mental health counseling or psychotherapy is usually tertiary, attempting to help children in major distress. Because crisis intervention includes primary preventative activities, school psychologists have clear sanction to work with all children in a school, with school staff, and with parents. Anticipating and ameliorating crisis brings together direct service roles and indirect service roles.

School personnel appreciate psychologists' quick and effective actions during times of crisis. Particularly in the elementary school, the school psychologist is usually the only mental health worker present, and the only one who can afford to take the time for limited, short term interventions in times of crisis. In addition, the school psychologist may be the only mental health professional perhaps known to the child and family and hence likely to be trusted. Principals report frustration when the assigned psychologist cannot be found in times of crisis at the school, and often hunt them down in other schools when they are in need. At this time, like no other, they recognize the psychologist's skills as being different from their own.

This focus on crisis counseling should not diminish the school psychologist's activities in more traditional counseling with special education populations. Recently it has become highlighted that the school psychologist has responsibilities for counseling children in special education programs particularly in the area of vocation and career development.

The goal of this mini-series on crisis counseling was to gather together experts on different kinds of crises that school age children typically face. Each has outlined what specifically can be done to help children regain equilibrium after a crisis event has taken place. They have discussed both direct counseling techniques and indirect interventions. They have also reviewed the research evidence and theory for techniques and interventions.

Authors in this issue have discussed specific crises of school failure, suicide, parental abuse, and adolescent sexuality. Scores of additional topics ranging from death to interpersonal conflicts might have been covered. It is my hope that school psychologists working with children encountering different kinds of stressful events, will research their efforts and report their results in these pages in future years. School psychologists can and must be able to facilitate the resolution of the multitude of crises facing children in schools.

In concluding, I wish to acknowledge and thank 14 able scholars who helped me review and refine the content of this mini-series. These individuals were: Jerry Roth, Myra Windmiller, Martin Covington, Nadine Lambert, Hannah Bauer, Susan Beecher Sandoval, Arlene Giordano, Donald Larson, Allan Gold, Susan Crockenberg, John Guidubaldi, Bonny Nastasi, Nancy J. Warren, and Pamela Hawkins.

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CRISIS COUNSELING: CONCEPTUALIZATIONS AND GENERAL PRINCIPLES

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ABSTRACT

This paper introduces the topic of crisis counseling and intervention and serves as a foundation for the other articles in this mini-series. It contains a brief history of crisis intervention stressing the seminal work of Lindemann and Caplan. Drawing on Baldwin (1978), a taxonomy is presented of six major types of emotional crisis in the school. The author argues that crisis counseling is different from other forms of counseling, particularly nondirective approaches, and proposes 13 generic crisis counseling principles. In addition, there is a discussion of five general prevention methods for use in schools. The author also cautions that any attempt at counseling or intervention must be adjusted to match the developmental level of the clients.

Helping children and adolescents in crisis requires quick wits, composure, and compassion. In addition to proper attitudes and predispositions, however, the effective school psychologist possesses a vital set of understandings and skills that are generic to the process. This article reviews the brief history of crisis intervention and counseling, outlines some major conceptualizations of the field, and formulates a number of general principles for direct intervention and preventive activities.

A Brief History of Crisis Intervention Theory

The earliest work on crisis intervention is usually attributed to Erich Lindemann (1944) and his studies of the aftermath of Coconut Grove nightclub fire. This disaster, which occurred in Boston in the late 1930's, took a huge toll of human life. For the first time a social scientist conducted systematic observations of the reactions of victims and their families to a natural disaster. This study plus Lindemann's efforts in opening a mental health agency in Wellesley, Massachusetts formed the basis of his ideas about crisis and crisis intervention. In Wellesley he was able to study such problems as children's entry into kindergarten and the process by which individuals become prepared to assume the position of nurse. From this work he was able to link notions of crises of transition with ideas about helping people cope with crises springing from traumatic events.

Eric Erickson (1962) contributed the next major milestone in crisis intervention theory with the publication in 1950 of *Childhood and Society*. Erickson's theory revolves around the notion of specific crises characterising each developmental stage of an individual's life. His contribution was the notion of crisis as a normal developmental phenomenon and that intervention which leads to a balanced resolution at the time of a crisis would prevent later problems in emotional development and maturation.

The third early pioneer was Gerald Caplan whose formulations about the primary prevention of emotional disorders and mental health consultation led to the notion of an entirely new field of preventative psychiatry (Caplan, 1961, 1964). Caplan's data came from early work with peace

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corps volunteers, with parents reacting to premature birth, and with families coping with the affliction of tuberculous. His and others' associated with the Harvard School of Public Health adoption of ideas from public health and application of them to mental health settings had an enormous influence that led to the blossoming of crisis intervention centers throughout the country.

Caplan's work came at a time when there was a great push on the part of the federal government for community mental health agencies and at a time of great social unrest in our country. The 1960's brought unprecedented illegal use of psychotropic drugs on the part of the adolescents and young adults. These forces, particularly drug abuse, led to the creation in the community and on college campuses of crisis counseling agencies, often nontraditional in nature, which could deal with the problems of alienated youth, particularly drug overdose (Beers & Foreman, 1976). During this time, the use of telephone crisis lines also came into widespread use, spurred on by a growing interest in suicide prevention services (Golan, 1978).

The late 1970s and early 80s have become a time when there is a great deal of interest in brief psychotherapy (e.g., Bellak & Small, 1978; Davanloo, 1978). This trend is a result both of cuts in mental health funding and in the emergence of new techniques and procedures for dealing rapidly with mental health problems. Mental health workers began to appreciate that as much could be accomplished in 6 to 8 sessions as had earlier had taken years. Crisis counseling has a relatively brief history and it is time for those in school psychology to learn more about these ideas and techniques for possible application to school settings.

Definitions of Crisis and Crisis Counseling

Over 2 decades ago Donald C. Klein and Erich Lindemann offered the following definition.

> An emotionally hazardous situation refers to any sudden alteration in the field of social forces within which the individual exists, such as the individual's expectations of himself and his relationships with others undergo change. Major categories of hazards include: (1) a loss or threatened loss of a significant relationship; (2) the introduction of one or more new individuals into social orbit; (3) transitions in social status and role relationships as a consequence of such factors as (a) maturation, (e.g., entry into adolescence), (b) achievement of a new social role (e.g., marriage), or (c) horizontal or vertical social mobility (e.g., job promotion). (Klein & Lindemann, 1961, p. 284)

They use the term hazard to capture the notion that many individuals are able to pass through such alterations with little difficulty or a minimum amount of stress. Others, however, find themselves immobilized or damaged by the hazard.

Klein and Lindemann reserve the term crisis "for the acute and often prolonged disturbance that may occur in an individual or social orbit as a result of an emotional hazard. The crisis of the individual is often a manifestation of a group crisis; conversely, the development of an interpersonal crisis may lead to a crisis situation for the group of which the individual is a significant member" (Klein & Lindemann, 1961, p. 284). Emotional hazards faced by school children include losses in significant relationships associated with the death of a parent, parental divorce and remarriage, death of a sibling, or the loss of a parent to illness; maturational challenges such as the beginning of puberty; and transitions such as those accompanying movement into new schools, or new educational programs. Nonpromotion is a hazard, but so is promotion to a new grade with its separation from a known, possibly favored teacher and the adjustment to change and an unknown, new teacher. Some children will navigate these hazards with little or no ill effect. Others will come to the attention of school psychologists.

Another innovator in this field, Gerald Caplan, offers a general view of an emotional crisis as a "psychological disequili-

brium in a person who confronts a hazardous circumstance that for him constitutes an important problem which he can, for the time being, neither escape nor solve with his customary problem solving resources" (Caplan, 1964, p. 53). Caplan views a crisis as being a period when the individual is temporarily out of balance. This state of disequilibrium provides an opportunity for psychological growth as well as a danger of psychological deterioration. Although there are great risks that may occur to the future mental well being of an individual who passes through a crisis, there is also an opportunity for an individual to change. It is an old cliche to point out that the Chinese character for crisis includes ideographs related to the concept of danger as well as the concept of opportunity. The primary goal in helping an individual who is undergoing a crisis is to intervene in such a way as to use the situation to enhance personal growth, or at least to restore the individual to a previous level of functioning. The goal is not to reorganize completely the individual's major dimensions of personality, but to restore the individual to creative problem solving. Of course by successfully resolving a crisis an individual will probably acquire new coping skills that will lead to improved functioning in new situations, but that is only a desired, possible outcome, not the fundamental objective of the process.

Although there are a number of ways that the crises may be defined and outlined, perhaps the most comprehensive taxonomy has been developed by Baldwin (1978). Baldwin noted six major types of emotional crises drawing on his work in a mental health clinic at the student health service at the University of North Carolina.

His first class of crises are known as *dispositional crises*. These crises are "distress resulting from a problematic situation in which the therapist responds to the client in ways peripheral to a therapeutic role; the intervention is not primarily directed at the emotional level" (Baldwin, 1978, p. 540). In a dispositional crisis an individual typically lacks both information and the general permission to go about solving a problem in an unusual way. The school psychologist who helps a pupil learn about a local program for over-weight teenagers might be dealing with such a crisis.

Baldwin's second category are crises of *anticipated life transitions*. He defines these crises as the type "that reflect anticipated but usually normative, life transitions over which the client may or may not have substantial control" (Baldwin, 1978, p. 542). Transitions such as entering school, childhood illness, the birth of a sibling all fit this category as well as physical transitions such as moving from one school or grade to another.

A third class of crises result from *traumatic stress*. These are "emotional crises precipitated by externally-imposed stressors or situations that are unexpected and uncontrolled, and that are emotionally overwhelming" (Baldwin, 1978, p. 543). The situations occurring with children in school are the sudden death of a family member, catastrophic illness, parental divorce, physical abuse or sexual assault. Often these kinds of crises are precipitated by a single traumatic event or by a series of events occurring rapidly together. Here the client is emotionally overwhelmed and unable to bring a previous learned coping strategy into play.

Baldwin's fourth category is *maturational/developmental crises*. These are crises "resulting from attempts to deal with an interpersonal situation reflecting a struggle with a deeper (but usually circumscribed) issue that has not been resolved adaptively in the past and that represents an attempt to gain emotional maturity" (Baldwin, 1978, p. 544). Baldwin gives examples of crises with focal issues involving dependency, value conflicts, sexual identity, capacity from emotional intimacy, responses to authority, or attaining reasonable self-discipline. All of these difficulties may occur in children in school and are different from others in that they usually occur as another episode in a pattern of relationship problems that have similar dynamics. Struggles with parents and teachers during adolescence often have the quality of a crisis of this class. In secondary schools, the attainment of sexual maturity by young people precipitates a number of these crisis, as does adolescence in general.

A fifth category of crises according to Baldwin is *crises reflecting psychopathology*. "These are emotional crises in which a preexisting psychopathology has been instrumental in precipitating the crisis or in which psychopathology significantly impairs or complicates adaptive resolution" (Baldwin, 1978, p. 546). A child hallucinating in school might be in great distress, for example. These kinds of crises, although present in the school, are often not the kind which the school psychologist is able to cope with or treat and thus usually are the subject of referral to outside community resources. The school psychologist does have a role in preventing deterioration by keeping the child functioning academically as well as possible. In addition the psychologist may assist school personnel to appreciate that the child has problems which cannot be resolved in school yet the school has ways of coping with the child.

A sixth category of crises consists of *psychiatric emergencies*. These are, "crisis situations in which general functioning has been severely impaired and the individual rendered incompetent or unable to assume personal responsibility" (Baldwin, 1978, p. 547). Examples include acutely suicidal clients, alcohol intoxification, drug overdoses, reactions to hallucinogenic drugs, acute psychoses, and uncontrollable anger. These are all "classic" crises of the type where the individual is often dangerous to himself or herself or others. Baldwin's distinctions are useful ones for they lead to different interventions on the part of the crisis counselor depending on what classification of crisis the individual is undergoing.

Although reactions differ, depending on the type of crisis, Dixon and Burns (1975) observe that there are three phases of a crisis through which an individual passes. First, the individual experiences the onset of the crisis. Often the reaction is to be stunned into inaction. Because the person is unable to use traditional problem solving strategies, the second phase involves the use of new or unusual problem solving mechanisms. Third, if the crisis does not move towards resolution, a phase of major disorganization, detachment and apathy will ensue. A child experiencing crisis may have a short attention span and tendency to focus on the obvious and concrete to the exclusion of the larger picture, may be introspective, may reach out to others emotionally and unable to control emotionality, may engage in a great deal of impulsive testing behavior, and may experience a change in relationship with others. Clients in these states of mind obviously need different counseling strategies than traditional voluntary counselees.

Often, however, the child is not aware he or she is in crisis. The crisis is experienced by other significant people such as teachers who become aware of a change in the child's mood, affect or behavior. In these cases, consultation with the significant person goes along with crisis intervention.

Differentiating Crisis Counseling from Other Forms of Counseling

Crisis counseling differs from other forms of counseling and psychotherapy on a number of dimensions. To begin, the goal of crisis counseling is to restore the client to equilibrium. As a result, it is more limited in its scope and briefer in duration than traditional nondirective counseling and psychotherapy. Encounters ranging from one meeting to eight sessions are the norm. A second goal is that of taking action rather than listening and allowing the client to take responsibility and control of his or her own decision-making and understanding. Accordingly, crisis counseling is far more directive than usual. A principle goal in traditional counseling is to avoid dependency on the counselor. In crisis counseling there may be times when temporary dependency is to be encouraged and is necessary to help a person survive extreme disequilibrium. Another feature that is different is the amount of talk by the counselor. Whereas in typical counseling and psychotherapy the counselor listens, reflects, and summarizes, in crisis counseling the counselor takes a much more active role in giving information and offering strategies to the client as well as giving advice and suggestions. Of course the crisis

counselor does use active listening techniques, too.

Other techniques having to do with the confrontation of a client and the use of self-disclosure and modeling probably have very little place in crisis counseling (Egan, 1982). These techniques are probably more relevant to personality change and thus are not as applicable, since the goal in crisis counseling is to restore equilibrium and to free the individual from troubling symptomatic behavior.

Another difference between crisis counseling and traditional counseling is the application of ethical principles. Concerns for the client's welfare should cause concern and heightened awareness of ethical principles that are not normally invoked in traditional counseling. There are times when the counselor must breach confidentiality (as when the client is a danger to self and others), when the counselor must carefully evaluate his or her own competence to continue with the client (as in dealing with possible psychotic conditions), and where the counselor must carefully consider and weigh parental permission and informed consent (as in dealing with substance abuse and abortion). The ethical challenges to the school psychologist are magnified given the nature of what can occur in a crisis situation, and its impact on a child's future lifetime adjustment.

Many similarities exist between crisis and traditional counseling. Certainly the active listening skills which characterize normal counseling are important to use in crisis counseling. It is very important to establish empathy and trust in the client, and the counselor has no better tools than reflecting feelings, restating the client's ideas, and summarizing (Benjamin, 1974). Carl Rogers' basic ideas of empathetic understanding, genuineness, and warmth all have their place in crisis counseling as well as traditional forms of counseling and psychotherapy.

Generic Crisis Counseling Principles

Given that crisis counseling is different from the usual process of counseling and psychotherapy, it is useful to indicate a general strategy for helping people in a crisis situation. What follows will be a general model culled from the work of Lindemann (1944), Caplan (1964), and Rusk (1971) and others (See Golan, 1978 for an exhaustive model). A counselor will change and adapt these techniques depending on the type of crisis, the age of the counselee, and the specifics of the type of crisis. Although I have outlined the principles in the general order that they are applied in a crisis, a different order of presentation might be possible.

1. *Intervene immediately.* By definition a crisis is a time when a client is in danger of becoming extremely impaired emotionally. The more the individual remains in a hazardous situation and is unable to take action, the more difficult it will be to facilitate coping and a return to equilibrium. The longer a person remains in a situation of confusion without any kind of human support the greater is the anxiety and pain that results.

2. *Be concerned and competent.* The client will need a certain amount of reassurance during a crisis situation. The more the counselor can present himself as a model of competent problem solving and demonstrate the process of taking in information, choosing between alternatives, and taking action, the more the counselee will be able to begin to function adequately.

3. *Listen to the facts of the situation.* Before proceeding the counselor must carefully gather information about the crisis inducing as many details as possible. Not only will solutions come from these facts but concrete knowledge of the situation will also shed light on whether the client is behaving rationally or irrationally, allowing the counselor to proceed accordingly.

4. *Reflect the client's feelings.* The counselor should explicitly focus the discussion on the client's affect and encourage its expression. The objective here is not only to create empathetic understanding, but also to legitimize affect and communicate that feelings can be discussed and are part of problem solving.

5. *Help the child accept that the crisis situation has occurred.* Do not accept the child's defensiveness and do not let the mechanisms of denial or other primitive defensives operate and prolong the crisis situation. Encourage the client to explore the crisis events without becoming overwhelmed.

7. *Do not encourage or support blaming.* This, too, is a way of avoiding crude defensiveness, leaving the way open to eventual coping with the crisis, or restoring healthy defenses.

8. *Do not give false reassurance.* The counselor should always remain truthful and realistic. The client in crisis will always suffer anxiety, depression or tension. At the same time it is possible to provide some sense of hope and expectation that the person will ultimately overcome the crisis. The notion here is that there will always be scars from a crisis and there will always be a residue of pain and emotional discomfort. Nevertheless a person will be able to get on with his or her life eventually, and may even develop new strengths.

9. *Recognize the primacy of taking action.* The individual will need real assistance in accomplishing everyday tasks during the time of crisis. Every crisis counseling interview should have as an ultimate outcome some action that the client is able to take. Restoring the client to the position of actor rather than victim is critical to success.

10. *Facilitate the reestablishment of a social support network.* If possible, get the child to accept some help from others. It is usually possible to find either a group of peers or family members that can both provide support and temporary assistance during the crisis time so that the client's energies may be devoted to resolving the crisis situation.

11. *Engage in focused problem solving.* Once the counselor has been able to formulate a comprehensive statement about the client's problem identifying all of the sources of concern, and once the client agrees on the statement of the problem, it will be possible to begin the process of exploring potential strategies to improve or resolve the emotionally hazardous situation. Jointly the psychologist and client review the strategies explored and select one for trial. This is much like the problem solving that occurs in other kinds of counseling but must be preceded by the steps mentioned above.

12. *Focus on self-concept.* Any strategies and any solutions to problem must be implemented in the context of what the client thinks it is possible for him or her to accomplish. The crisis situation often leads to a diminution in self-esteem and the acceptance of blame for the crisis. With an emphasis on how the person did cope well given the situation so far and how the person has arrived at a strategy for moving forward, there can be a restoration of the damaged view of the self.

13. *Encourage self-reliance.* During the process of crisis counseling, the counselee will have temporarily become dependent on the counselor for direct advice, for stimulating for action, and supplying hope. This is a temporary situation and before the crisis intervention interviews are over, the counselor must spend some time planning on ways to restore the individual to self-reliance and self-confidence. Typically in counseling this is done by the counselor consciously moving into a position of coequal with the client and sharing in the responsibilities and authority in the situation. Although this may have earlier been abandoned, making sure that techniques such as onedownsmanship occur, where the counselor acknowledges the client's contribution to problem solving while minimizing the counselor's own contribution (Caplan, 1970), the counselee will be able to leave the crisis intervention with a sense of self-responsibility.

Although these principles may generally apply to crisis counseling, Baldwin has added to his taxonomy a notion about specific techniques that are appropriately applied given the problem fits one classification or another. Table 1 presents Baldwin's taxonomy and the interventions that are linked to each of the types of crisis counseling.

The authors of the rest of the articles in this issue will explicitly address techniques that are important to attend to in dealing with particular kinds of crises. In dealing with a particular type of client or

TABLE 1

Interventions Particularly Relevant to Baldwin's Six Classes of Emotional Crisis

Crisis Type	General Intervention
1. Dispositional Crises	• Provide information — educate • Rule out hidden, serious emotional implications • Refer to expert
2. Anticipated Life Transitions	• Anticipatory guidance • Provide support groups
3. Traumatic Stress	• Help client understand the impact of what has occurred • Mobilize existing coping mechanisms • Provide new coping mechanisms
4. Maturational/Developmental Crises	• Identify issues underlying crisis • Support client in redefining relationships and developing adaptive interpersonal responses
5. Crises Reflecting Psychopathology	• Support attempts to respond to stressful situation as adaptively as possible • Find ways to reduce stress • Refer to experts • Do not respond to underlying problems
6. Psychiatric Emergencies	• Intervene quickly to reduce danger • Assess medical or psychiatric condition • Clarify situation • Mobilize all medical or psychiatric resources necessary

predicament, certain kinds of information may be important to communicate that are unique to the situation. Nevertheless the above principles will generally apply in most situations.

The Prevention of Crisis Situations

Caplan, coming as he does from a public health point of view, stresses the prevention of crises. At least five general strategies have been used in the schools to prevent various kinds of crises from occurring. They are educational workshops, anticipatory guidance, screening, consultation, and research (Sandoval, 1982).

An educational workshop is a short intensive course of study emphasizing student participation and discussion. It is preventive to the extent that the topic of the workshop is intended to forestall future educational problems. A number of programs exist for children under the general heading of psychological education. Programs such as classroom meetings, magic circle, and others help children express their feelings about what is occurring in the social environment of the classroom, and attempts to free them from the

anxiety that may occur from crisis situations. Others have pointed out the value of a psychologist's role in all curriculum design (Jones, 1968).

The second technique, known as anticipatory guidance, also has a variant called emotional innoculation. Offering participatory guidance consists of orienting a person to events that are likely to occur in the future and helping him or her prepare effective coping strategies. Emotional innoculation puts the emphasis on future feelings rather than on the cognitive. Events in question are ones that experience has shown are difficult for individuals to cope with and may influence educational performance. Examples of anticipatory guidance are courses in death and dying, orientation programs designed to help children adjust to new institutional settings, and letting adolescents know what to expect when they are about to go to a hospital for a medical procedure.

A third preventative technique is to implement screening programs. Screening programs consist of designing techniques (usually questionnaires, rating scales, or group tests) to determine who is at a high risk of encountering a particular type of crisis, and then assigning any individuals identified to an appropriate intervention. Intervention may be anticipatory guidance, a workshop or a special remediation program. Screening has been particularly effective in identifying children who are at risk of educational failure but it is conceivable that screening could be designed to identify children who are also at risk for other kinds of crises. An example would be an effort to learn which families, in the near future, plan to enlarge their numbers so that children might be identified for workshops designed to facilitate the adjustment to a new sibling.

Serving as a consultant is another important way that a psychologist can act preventatively in crises. Consultation is defined as one professional helping a second professional be more effective in his or her job. For the purposes of this paper a consultant is defined as a school psychologist collaborating with teachers, administrators, or parents to help them deal more effectively with the child or teacher in crisis. By working with teachers, and possibly with parents, a psychologist can help these key adults support children when they become involved in a crisis situation and be sensitive to the various emotional needs a child may have during times of crisis.

Research is not usually conceived of as a preventive activity. Nevertheless, the more that is known about a phenomenon through research the better able we are to predict and control that phenomenon. The more we understand about crises, the more we will be able to include in crisis, intervention workshops, educational curriculum, anticipatory guidance programs, screening programs, and consultation.

Developmental Issues in Crisis Counseling

A number of texts and articles on counseling and psychotherapy for children ignore the obvious. A child of 4 and an adolescent of 17 have radically different faculties for dealing with information and reacting to events. Differences in cognitive, social, and emotional development mean that they will respond differently to events and will need to be counseled accordingly. The same event, the divorce of parents, for example, may be a crisis for a preschooler as well as a high school senior, but each will react and cope with the event in a different way and each will need to be counseled using somewhat different techniques. Counseling with younger children often involves the use of nonverbal materials, much more directive leads in order to elicit and reflect feelings, and we must focus on more concrete concerns and factual bits of information as well as fantasy.

Traditional talk therapies such as nondirective counseling capitalize on a client's capacity for rational thought and high level of moral development are effective with adolescents. With adolescents, the school psychologist can also acknowledge the age-appropriate crisis of establishing an identity. In reviewing the generic crisis counseling principles above, it seems reasonable to expect that younger clients would have a greater difficulty acknowledging a crisis, and would be more prone to

use immature defenses such as denial and projection to avoid coping with a crisis whereas the adolescent may use more advanced forms such as intellectualization. In counseling children more time would be spent on exploring reactions and feelings to the crisis situation and establishing support systems than engaging in lengthy problem solving. With older clients, then, it may be possible to focus much more on establishing reasonable expectations and avoiding false reassurance, as well as spending more time on focused problem solving activities.

Conclusion

School psychologists have a powerful role to play in helping children cope with and regain equilibrium after the onslaught of a crisis situation. Adding together the six classes of crises defined by Baldwin yields a large number of events that occur in the school age population and which undoubtedly interfere with the effective learning of children in schools. The techniques of crisis counseling have a relatively short history in being applied and differentiated. Nevertheless, it is possible to see that the crisis counselor operates differently with the client than does a traditional counselor. Much of what is done with the client depends upon what kind of crisis it is, the age of the child, the time available to the counselor, and the counselor's skills. To be efficient, group interventions that are preventive in nature may be necessary to cope with the strong need for crisis counseling in the schools. The remainder of the articles in this mini-series will deal with crisis counseling and intervention in particular kinds of situations. Through all of the articles, however, runs the thread of intervening briefly and effectively with children in schools. School psychologists can have an enormous impact on the mental health of children if they are aware of and act immediately in helping them develop positive coping in crisis situations.

Children may regain equilibrium, not lose precious time away from learning to emotional disorganization, and possibly even develop successful new problem solving strategies as a result of successfully negotiating a crisis. Such clients hopefully will be able to face emotional hazards throughout their lifetimes with a greater degree of confidence and success.

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BEST PRACTICES IN CRISIS INTERVENTION

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Frequently in the literature on crisis intervention, crises are characterized not only as times of danger but also of opportunity. Therefore, many of the assumptions of crisis theory and practice are useful to school psychologists who certainly are not strangers to situations which evoke either possibility. Very recently, in a chapter on crisis intervention in the schools, the case was made that school psychologists along with other personnel should receive training in handling crises (Nelson & Slaikeu, 1984). However, to date there appear to be few reports of school psychologists using these approaches. The intent of this chapter is to review some of the major premises of crisis theory and practice. Areas of potential applicability are highlighted as are possible cautions and limitations.

OVERVIEW

The foundations of crisis theory and practice were established in large part by Erich Lindemann (Lindemann, 1944, 1979) and Gerald Caplan (Caplan, 1961, 1964). A "critical event" was a crisis situation, the tragic fire in Boston's Coconut Grove nightclub in 1943 (Korchin, 1976). Based upon his work with relatives of the deceased as well as others in threatening situations, Lindemann documented predictable stages of grief and possible means of intervention. In 1948 Lindemann and Caplan established the Wellesley Human Relations Service, a community mental health program where they implemented their formulations (Darbonne, 1967).

Crisis intervention received ready acceptance in the mental health field which previously had focused only on those with long-term illnesses (Farberow, 1978). It became an attractive alternative to psychotherapy for persons in immediate distress. Suicide prevention/crisis intervention centers and telephone hotlines multiplied. The idea that some crises might be anticipated and prepared for also suggested possibilities for prevention (Caplan, 1964).

Generally, from the perspective of crisis intervention theory, a *crisis* is seen as a period of psychological disequilibrium in the face of a hazardous event which can neither be escaped nor solved with customary problem-solving resources (Caplan, 1964). Students unable to cope with parental divorce, a failing grade, entering a new school, or losing a boyfriend may be referred to the school psychologist in a crisis state. Perhaps even more frequently, children referred for learning problems are having such difficulties due to crises related to hazards at home or at school.

Crisis reaction refers to the state of upset persons in crisis are undergoing. Typically, they experience feelings of helplessness, inadequacy, confusion, anxiety, and tiredness as well as disorganization in work and interpersonal relationships (Halpern, 1973). Lowered self-esteem and depression also have been documented (Lewis, Gottesman, and Gutstein, 1979). It's not difficult to see how school learning is disrupted.

Crisis intervention is designed to restore psychological equilibrium by improving coping skills and offering new alternatives for dealing with the troubling situation and the stress it is creating. Crisis reactions are not necessarily signs of pathology or emotional disturbance (Golan, 1978), but in many cases are short-term normal responses. Though antecedent fac-

tors such as individual personality or experience might "... load the dice in favor of a good or bad outcome," emotional disequilibrium is to be expected when faced with an important and insoluable problem (Caplan, 1964, p. 53). Therefore, crisis intervention is not usually directed towards the restructuring of basic personality as is seen in psychotherapy, but towards resolution of present problems and emotional conflicts (Auerbach & Kilmann, 1977).

Crises are times of increased vulnerability, however. Puryear (1979) notes that the individual in crisis "... is at the end of his rope, having tried everything he knows and can think of. He has finally succumbed" (p. 41). In such a state, people are quite susceptible to outside assistance. Caplan warns that such vulnerability not only provides the opportunity for growth but also threatens deterioration in personality and life situation (Caplan, 1964). Thus, a poorly resolved crisis does not bode well for future mental health. Conversely, timely intervention not only aids in alleviating immediate distress, but also in promoting positive mental health.

Implications for the school psychologist are multiple. First, in our mobile, highly industrialized society where knowledge and technology continue to increase at an explosive rate (Adams, 1980; Toffler, 1971), most people, by definition, seem to be susceptible to crises. Possibly, "... as never before in history, individuals are faced with the task of adapting to frequent and often abrupt life changes" (Felner, et al., 1983, p. 199). If crises states are not ipso facto signs of mental illness, and if intervention does not necessitate long-term psychotherapy, then highly specialized mental health professionals are not always required to aid those in crisis. As Korchin (1976) points out, "Crisis is universal and crisis intervention is everybody's business" (p. 502). Probably in the school situation it is the school psychologist's business.

Knowledge in this area should aid in recognizing, responding to, and, in some cases, alleviating individual and family crises. More global crisis situations which affect many members of the school also can be anticipated. Provisions are made for potential hazards such as redistricting, teacher lay-offs and sudden teacher or student death. Such knowledge also sensitizes school psychologists to how much is left to be learned about how people handle and adjust to hazardous events. Caplan (1976) admonishes, "Fundamental questions about the efficacy of crisis intervention have not been answered ... we do not know whether such intervention is in fact successful in the short or long run ..." (p. xxiii). Even more recently, lack of evaluative data was cited as a major deficiency in the literature on crisis intervention in the schools (Nelson & Slaikeu, 1984).

Basic Considerations

In this section, information in three overlapping areas is presented. First, knowledge which can be brought to bear in *recognizing crisis situations* is reviewed. Current formulations concerning crises, types of crisis situations and variations in crisis reactions are discussed. Such information is useful to the diagnostician when assessing learning, behavioral, or emotional difficulties. Crisis states can be documented and possible contaminatory effects on test results recognized. Times when diagnosis itself promotes crisis also are suggested. Having one's child diagnosed as mentally retarded or learning disabled, for instance, constitutes a hazardous event for which some parents may have no coping strategies or resources.

Second, knowledge and skills which are useful in *responding to crisis situations* are presented. Building on the preceding information, this area addresses basic approaches to crisis intervention

and then tailors them to particular roles the school psychologist plays. Possibilities for consultant-liaison work, crisis counseling and system-wide intervention in emergencies are targeted.

Finally, time is devoted to *planning for crises* of the future. Possibilities for prevention and in-service education are highlighted.

Recognizing Crisis Situations

Often recognizing crisis situations is not as cut and dried as we think. As a construct, crisis does not have an established meaning or formal theoretical base (Auerbach & Klimann, 1977). Generally, presence of a hazardous event coupled with evidence that the individual has been unable to adapt to its occurrence is a good starting point.

Crises are often subdivided into those which are accidental or situational and those which are maturational or developmental. Predictability of the hazardous event for groups of people is largely at issue. Some hazards and associated crises are purely accidental. They befall individuals or groups. Sudden death of a family member, a serious car accident, or devastation of the school by a hurricane fall at the accidental end of the continuum. Other situational crises do not come as a complete surprise, however. Not being promoted to the next grade, getting one's first C, or teacher lay-offs constitute not entirely unexpected hazards.

Maturational or developmental crises, on the other hand, are more predictable on a group-wide basis. Most children are exposed to the potential hazards of starting school, making the move from elementary to junior high school, and adjusting to the socio-emotional and physical consequences of puberty. Both developmental life stages and times of transition from one condition to another (Golan, 1978) are considered areas for these more predictable hazards.

Crisis reactions are elicited by a range of stressful life events (Auerbach & Kilmann, 1977). Familiarity with Holmes and Rahe's (1967) Social Readjustment Rating Scale and Yeaworth et al. (1980) Adolescent Life Change Scale are helpful in sensitizing the school psychologist to some of the common stressors and their relative ratings on a group basis (also see Wise, in press).

Presence of a potentially hazardous event is not by itself evidence of crisis however. First, individuals must perceive the event as important and threatening and, second, they must be unable to deal with it. Knowledge concerning the individual's life goals and feelings about the event is essential, as is knowledge about their current life situation and coping resources. For instance, starting a new school late in the year probably constitutes a hazardous event for many students. One or two, however, see it as a very positive occurrence. For many of the rest, though, it is perceived as hazardous, they find that they can cope given their existing strategies for dealing with stress and fitting into new situations.

Puryear (1979) discusses various instances where people find that they cannot cope. Sometimes the problem is just too overwhelming, such as death of a family member. Other times several small problems over a short period of time have depleted the individual's ability to cope. In these cases there is not one hallmark hazardous event. For example, a first-year teacher who gets married and relocates finally goes into crisis when asked to do extra coaching after school. In still other instances, existing coping mechanisms are blocked. Moving is more likely to trigger crisis for a child who has always turned to a particular parent for support if it coincides with repeated absences on that parent's part. Situations also induce crises if they involve new and unique problems for

which appropriate coping mechanisms have not been developed.

In addition, symbolic links to similar problems in the past which were not appropriately resolved have an effect (Caplan, 1964; Golan, 1978; Lukton, 1982). For instance, in the case of the accidental death of a fourth grader reported by Keith and Ellis (1978) his teacher's inability to aid her class in responding appeared to be based on such links (Nelson & Slaikeu, 1984). She had experienced several painful deaths in the past and this death "... stirred up repressed feelings about the loss of other important persons..." (Nelson & Slaikeu, 1984, p. 252).

Further evidence that an individual is in crisis comes from indications of the psychological disequilibrium associated with crisis reactions. Often people feel as out of control of their emotions as of the practical effects of the hazardous event. If an individual who previously has been functioning adequately begins manifesting anxiety, helplessness, lowered self esteem and depression, then additional evidence for an inability to cope has been secured.

However, individual variations in the intensity of these reactions have been documented (Halpern, 1973). In another instance, different emotions were found to develop at different times (Lewis, et. al., 1979). Patients learning that they had cancer experienced anxiety and helplessness almost immediately, while depression and lowered self-esteem did not develop until several weeks later. Difficulty in recognition also occurs with those individuals who do have more long-term emotional difficulties. While crisis reactions are not of necessity signs of pathology, those with previous pathology are not immune to them.

Often in the literature, the short-term nature of crisis reactions is highlighted as a further diagnostic indicator. Originally, both Caplan and Lindemann saw crisis reactions as being time-limited. The belief was that within four to six weeks, emotional equilibrium was re-established whether the crisis was resolved well or not. More recently, this issue like the determination of a hazardous event, appears less clear. Though some hazards are of sufficient impact that a state of active crisis is immediately precipitated, usually they bring out predictable efforts to cope (Golan, 1978). Tension rises to a peak only when neither customary nor newly initiated problem-solving mechanisms have helped. As Golan (1978) suggests, finally a turning point is reached, often triggered by some precipitating event or series of small precipitants and the state of active crisis entered. Thus, time between hazardous event and crisis reaction varies. In some cases symptoms associated with active crisis last considerably longer than six weeks as well (Lewis et. al., 1979). Several have suggested that the initial crisis state is followed by a prolonged period of adjustment (Caplan, 1976; Lukton, 1982; Felner, et. al., 1983).

Summarizing this information on crises and reactions to them, several suggestions emerge for recognizing crisis situations. Look for an event or series of events which are important to the individual and perceived as hazardous. Look for evidence that he or she has been unable to cope using either traditional or newly initiated strategies. Look for signs of emotional disequilibrium. A short-term time-frame provides further evidence. However, timing between hazardous event and the turning point to active crisis varies as does the duration of emotional disequilibrium.

The following flow chart may be useful:

1.) Potentially Hazardous Event(s):
- ↓ Accidental-sudden death
- Situational-suspended from school
- Maturational-starting kindergarten
- Developmental-puberty

2.) Individual Perception of the Event as Threatening:
   - ↓ Important challenge to personal satisfaction or goals

3.) Individual Inability to Cope:
   - ↓ Neither traditional nor newly-initiated strategies aid in avoiding or adjusting to the hazard. Inability to cope may be due to: trauma of hazardous event, many small problems depleting ability to cope, existing coping mechanisms blocked, novelty of hazardous event, or symbolic linkages with unresolved problems.

4.) Crisis Reaction:
   - ↓ anxiety, helplessness, confusion, depression, lowered self-esteem, disorganization in work and interpersonal life.

Responding to Crisis Situations

What follows is an attempt at targeting common practices in crisis intervention so that the school psychologist has some immediate direction. Though there is much consistency in terms of the distinguishing characteristics of intervention efforts (Slaikeu, 1984), "... techniques are loosely organized and cover various procedures" (Auerbach & Kilmann, 1977). See the last section of this article for several variations.

The hallmarks of crisis intervention efforts are immediacy and flexibility. The thought is that persons in crisis need help and they need it without delay. As in most situations the psychologist encounters, efforts are made to establish rapport first. Often this is aided by allowing the individuals involved plenty of time to ventilate feelings of distress and helplessness. Active listening or empathic responding are useful in establishing a supportive relationship while allowing people room to express themselves (see Eddy, Lawson & Stilson, 1983 for descriptions of this technique). Once rapport has been established, probes for further indications of a crisis state and particular individual needs are employed. Often indications of dangerousness to self and others must be considered. Individuals who are stuck, feeling unable to cope with an important and threatening situation, may become suicidal or violent (see Eddy, et. al., 1983, and Slaikeu, 1984, for information on assessing lethality).

After initial information has been collected and a supportive relationship established, then attention shifts to providing assistance in handling and resolving the crisis situation. Generally, advice and information are given. However, efforts are made to discourage undue dependence (Korchin, 1976). One area of information useful with adolescents and adults is what this author calls translating normality; that is, sharing some of the preceding information on crises and what to expect. The idea that these are normal, perhaps time-limited responses can make their own experience more comprehensible and less threatening (also see Smith, 1976, last section).

Immediate efforts to mobilize resources are critical. The intervenor is actively involved in obtaining human and agency resources which facilitate clients' readjustment (Auerbach & Kilmann, 1977). Such efforts are familiar to the school psychologist who is used to coordinating between child, parent, teacher and whatever resources are necessary to alleviate the problem at hand. Balancing such active intervention with the need not to foster undue dependency can be tricky. Generally, individuals are made aware of resources and encouraged to do that which they can for themselves. The intervenor assists with that which is too overwhelming for the moment (see Puryear, 1979, last section).

Individuals are also assisted in considering different ways they, themselves, can approach and attempt to resolve the crisis situation. A frequent theme in crisis intervention is an emphasis on client competence, mastery, and capacity for autonomy (see Bloom, 1977; Korchin, 1976). Active involvement of the client is encouraged in considering options for dealing with the hazardous event and the stress it is engendering. If new more adaptive coping strategies are identified and the seemingly insurmountable conquered, then not only may immediate distress dissipate, but future growth occur.

Because schemes for conceptualizing and evaluating coping differ, the psychologist and crisis client need to consider a variety of options. Caplan (1964) suggested that strategies be reality-based and not rest on inappropriate defense mechanisms, or involve a retreat from life. A generic approach to crisis intervention based on his work and Lindemann's stages of grieving is sometimes employed. As summarized by Lukton (1982), clients are aided through a denial stage and led past periods of anger, confusion, guilt, or depression to cognitive exploration of the situation and of possible coping strategies (see Lindemann 1944 for more on stages of grieving). Tasks which are thought to be necessary in confronting particular developmental or situational crises are used in such a generic approach (see Lukton, 1982; Smith, 1976).

One general scheme for organizing coping strategies comes from work by Pearlin and Schooler (1978). They found that persons attempted to combat various life stresses using strategies within three areas. Some strategies involved direct change of the situation. Others addressed the meaning of the situation, and still others were directed towards the stress engendered by the situation. Using this format, strategies the client has already attempted in each area are elicited first, then new alternatives are generated.

For instance, in working with a teenager in crisis over an unwanted pregnancy, various changes in the situation are possible. She may only perceive the two options of marriage or abortion. Others such as single parenthood, adoption, or raising the child within her extended family would be raised and considered. The meaning she gives to the situation is another change point. As discussed, individual perception is important in documenting that an event is harzardous. Changes in perception may remove an event from this category and/or cut down on stress. If this teenager is seeing herself as a failure or her life as ruined, then alternative meanings may reduce disequilibrium independent of changes in the situation. Finally, her typical methods of coping with stress are reviewed and applied to this new situation. She might consider spending more time with friends and sharing her troubles with one or two confidants. New possibilities for stress reduction are also raised.

Research in the areas of life events, stress, and coping offers a variety of possible strategies to be considered when exploring alternatives in each category (see Antonovsky, 1979 and Kobasa, 1979 in addition to those cited below). Such research also suggests that caution be taken when attempting to identify the most adaptive options. As yet, a widely accepted taxonomy of coping does not exist (Roskies & Lazarus, 1980). Methodological difficulties make existing studies of coping efficiency problematical (Murgatroyd, 1982). One area, the importance of social support as a buffer against stress, has received repeated endorsements. Other areas, such as the necessity for immediately action-oriented, reality-based approaches are less clear. For instance, Roskies & Lazarus (1980) speculate that temporarily accepting helplessness and reducing distress however possible, even using denial, may be helpful. Elsewhere,

women's success in adjusting to breast cancer appeared to rest "...fundamentally upon the ability to form and maintain a set of illusions" (Taylor, 1983, p. 1161). For instance, these women persisted in believing that they had control over the cancer despite little evidence of such. They also enhanced self-esteem through comparing themselves to others worse off even when such persons had to be created.

Others emphasize the importance of coping not only with the time of active crisis but also with the more long-term period of adjustment which follows (see Felner, et. al., 1983). Coping with any major threat often involves an amalgam of many diverse coping acts performed over time and in multiple contexts (Roskies & Lazarus, 1980, p. 48).

Thus, the crisis client and psychologist, of necessity, explore various options for changing the situation, its meaning, and handling stress. The author finds that the realization that options exist is useful in combating the feeling of being trapped and changing the meaning of the situation. Continuing to generate new alternatives in a tight situation also bodes well for mental health in the future. Once options have been identified, the client is in a position to make choices and take action. The degree of continued involvement of the helper varies. At this point roles the school psychologist assumes are discussed.

All involve recognizing crises and responding to them, through active listening, support, and perhaps some explanation of what is transpiring. If there is no indication of danger to self or others, and no wish for further assistance on the clients' part, the psychologist withdraws. Taylor (1983) argues, based on several research reports, that most persons sustaining severe personal tragedies readjusted well and achieved "...a quality of life or level of happiness equivalent to or even exceeding their prior level of satisfaction" (p. 1151). What is more, most did so without the aid of professional assistance (Taylor, 1983).

However, if in the judgment of those involved more assistance is needed, help is provided by mobilizing resources and/or generating alternative coping strategies. These activities are approached from a consultant-liaison role alone or supplemented by individual or family crisis counseling.

In identifying necessary resources, both emergency provisions for day-to-day existence (food stamps, baby sitters, tutors, etc.) and sources of social support (forgotten relatives, old friends, support groups) are considered. Mental health and crisis intervention specialists also are important resources. Though ethical standards have rarely been raised in discussing crisis intervention (Golan, 1978), often professional training or access to mental health specialists is assumed. Indications of danger to self and others, of more long-standing difficulties, and of repeated life crises often point in this direction. In such cases school psychologists serve as liaisons between crisis agency or mental health specialist and the school. They also assist in coordinating with the family and other community agencies and generating and implementing alternative strategies for resolving the crisis.

In cases where time, training, and interest allow, the psychologist goes beyond liaison and consultant efforts to more extensive crisis counseling with the child or family (in addition to the last section of this article see Ewing, 1978; Golan, 1978; and Murgatroyd, 1982 for different approaches). Group work with students or teachers undergoing similar crises is also a possibility. In the counselor role more time is spent on generating and testing alternative strategies. Personal meanings and individual differences in life situation (see Lukton, 1982) are explored in more detail. Possible symbolic linkages to earlier events are addressed, and when appropriate, the

grieving process facilitated. Student crises often benefit from direct exploration and coordination efforts with teachers and parents. When appropriate, their aid is elicited in restructuring the situation, altering meanings, and reducing stress. They prove an important source of social support as well.

Finally, this information offers suggestions for dealing with school-wide emergency situations such as sudden death of a student or devastation by storm. First, it is useful to distinguish between emergencies and crises as the term is used here. Though emergencies may often trigger crises, the two are not synonymous. For some, the particular emergency is not threatening given their situation and goals; others find that they are able to cope. Emergencies, therefore, are seen as potentially hazardous events for some, but not all persons.

A major order of business, then, becomes precluding unnecessary crises. Attention is immediately directed toward defusing the potential hazard and/or helping people to cope with it. Appropriate physical and interpersonal resources are mobilized quickly. Attempts are made to foster social support and accurate communication among members of the school body. Information about the particular hazard and about potential coping strategies aids in influencing the meanings persons are attaching to the event and in coping with its effects.

Many of these efforts are made on a group-wide basis working with teachers and students. However, individual differences are kept in mind. At one extreme, efforts are made to identify those already in crisis or at high risk in order to extend special attention. At the other, the psychologist is sensitive to those who, for whatever reason, do not respond well to group discussions or unsolicited attention (see Parad, Resnik, and Parad, 1976 for information on emergency and disaster management).

Planning for Crises of the Future

Rather than waiting and "putting out fires," it is tempting to think in terms of prevention and crisis-proofing students and teachers. This possibility of "anticipatory guidance" or "emotional inoculation" was conceived early in the development of crisis theory (Caplan, 1964). He suggested that preventive programs anticipate hazardous events which could be expected to trigger crises in a significant portion of the target population. In individual or small group discussions, the preventor attempts to evolve a vivid anticipation of the event and associated negative feelings. Next, ways of solving the problem, including mastering negative affects, are explored. Thus, "... the hazards will be attenuated because they have been made familiar by being anticipated, and the individuals will already have been set on the path of healthy coping responses" (Caplan, 1964, p. 84).

The notion of anticipatory crisis intervention is not essentially new; many organizations run orientation programs for new members (Korchin, 1976). In fact, "... all of education has been called, more or less accurately, 'preparation for life' " (Korchin, 1976, p. 508). Information from previous sections adds to what could be attempted, as does the increasing data base on preventative mental health (Felner, Jason, Moritsugu, & Farber, 1983). For instance, social support networks within the schools might be identified and made more accessible. Previous cautions are also applicable. See Lukton (1982) for others.

BEST PRACTICES

This section might more appropriately be subtitled, "Possible Practices." As yet, the point has not been reached where

"tried and true" strategies can be summarized (Slaikeu, 1984, p. 77). Selections have been chosen which relate to issues raised previously. In summarizing these efforts, much has been de-emphasized. The reader is referred to these sources for nuance and complexity, as well as a firm grasp of major points.

Smith (1976), building upon the work of others, offers one fairly traditional approach to working with individuals. Treatment is time-limited. However, it continues until the crisis is resolved whether this takes six to eight weeks or beyond. The initial contact, which may take two to three hours, is directed toward six tasks. First, the worker must determine if the client is in a crisis state. Next, the client is encouraged to express and ventilate feelings. Such expression he feels allows necessary emotional catharsis as well as facilitates building a therapeutic relationship. Then the intervenor begins exploring how the client has approached the problem and why he or she is failing. Of interest is which problem-solving and coping strategies have been used and who besides the client is involved in the crisis. Assessment is also directed toward risk of suicide and homicide and whether there is a need for emergency hospitalization.

At this point the client is helped to understand why the crisis is occurring. Understanding is directed not only toward the precipitants, but toward understanding why solutions have not been reached. As the reaction becomes more comprehensible, the client usually feels less confused and out of control. Smith believes that when appropriate, the intervenor should explain that ". . . most people faced with similar problems would be reacting in the same way" (p. 204). The intervenor also attempts to instill hope. A good starting place is often where the client is struggling the most. Alternatives are explored, and efforts are made to show that help is on the way.

In subsequent sessions, additional tasks and problem-solving strategies are explored. Communication skills are used. Smith uses generic strategies when they are available but makes adjustments in accord with individual client needs. Intervention is ended when equilibrium in social functioning has been established, and the client has completed the psychological tasks associated with particular crises. Anticipatory guidance is used at this point. Successful strategies are reviewed in anticipation of future hazardous situations. If "underlying pathological malfunctioning" is suspected, need for referral and other treatment is discussed. Finally, the client is encouraged to return for further help if the need arises.

Puryear (1979) presents a family-oriented approach to crisis intervention. As described in the introductory chapters, it involves eight intervention principles derived from work with individuals, but applying to families, and ". . . working with a family is usually the best way to approach crisis intervention" (p. 2). Crisis intervention is not seen as psychotherapy. Puryear emphasizes the distinction and cautions that counselors or therapists sometimes erroneously slip into doing therapy when intending to do crisis intervention.

Puryear's approach which is derived from systems theory, personality theory, and crisis theory is designed to promote successful crisis resolution in one to six sessions which are supplemented by telephone calls. His principles involve immediate action-oriented intervention with limited goals. Over all, intervention seeks to restore equilibrium, ". . . hopefully with some growth also occurring" (p. 21). Its minimal goal is averting catastrophe. Puryear lists permanent disintegration of the family as one possible disastrous ending. He is referring to those situations where communication and acknowledged emotional ties with one family member are severed.

In seeking to restore equilibrium, his intent is neither direct personality change nor change in the basic pattern of precrisis family functioning. For instance, a crisis situation revolving around loss of a job or a wife's pregnancy might occur in a family whose typical pattern of functioning includes an alcoholic husband who becomes drunk every weekend. Attempting to stop the father's drinking is not considered an appropriate goal for intervention. Instead, the thrust of Puryear's approach is in defining the immediate problem and then resolving it through focused problem-solving.

The crisis intervenor is active. He or she listens enough so that the clients feel attended to and understood, but formulating a clear statement of the problem and developing a specific, concrete plan of action are key. Generally, feelings are dealt with only as much as necessary. Some ventilation and exploration are encouraged initially but as soon as possible feelings are related to the problem at hand. Problem definitions which facilitate problem-solving are chosen. For instance, " 'the family hasn't yet adjusted to Mother's death,' " is preferred to " 'Mother died' " (p. 36). In cases involving delayed grief responses where unexpressed feelings are primary, the emotions are brought into the problem-solving framework. The problem becomes, " 'the client has not yet dealt with his feeling about something' " (p. 38). In such special cases, Puryear feels intervention sometimes comes closest to resembling therapy.

Crisis clients are also active, working as a team with the intervenor in defining the problem and planning its solution. Puryear points out that most clients are not stupid. If easy, simple solutions were available, they usually would not ask for help. Intervenors do not present themselves as experts at solving others' problems, but as people with expertise in the process of problem-solving who will work with them. As well as attempting to foster hope and the expectation that the problem can be solved, attempts are also made to improve self-image and promote self-reliance through the focused problem-solving process. Puryear feels that it is important that clients leave the first meeting with a task they can accomplish. Over the course of intervention, things are not done for clients if they can do them on their own. Intervenors convey the attitude that ". . . the client is a capable, decent person who has been temporarily overwhelmed by extreme stresses, and who will use your help to cope with these stresses and get back on the track" (p. 43).

Nelson and Slaikeu (1984) offer suggestions tailored specifically to the schools. They point out that because of the regular amount of time students spend there, school personnel have a unique opportunity to recognize and respond to crises. Because at times of crisis, children are vulnerable to new ideas, methods, and ways of conceptualizing, crisis intervention is not seen as an extra duty. Instead, it is very compatible with the goal of ". . . growth and development based on learning" (p. 247). Knowledge gained in crisis ". . . might be very difficult, if not impossible, to achieve when things are more 'normal' " (p. 247). In fact, almost a guarantee that the classroom teacher has the classes' undivided attention occurs during crisis situations such as death and illness of other school members.

In tailoring crisis intervention to school settings, administrative support is important. They should include crisis services in the job descriptions of all personnel from secretaries and administrators to teachers and counselors. Agreement is secured ahead of time so that, when crises occur, the regular curriculum is modified sufficiently that class discussions or individual conferences are devoted to resolving and learning from the crisis. Parents and community agencies must be involved as

well. In crisis situations where many students are affected, ". . . meetings which include parents, school personnel, social service workers, police and the like, should be the rule rather than the exception." (p. 256).

Two techniques which school personnel use in responding to crises are presented. Both methods, psychological first aid and crisis therapy, are described by Slaikeu (1984). Nelson and Slaikeu feel that virtually all school personnel should be trained in psychological first aid which involves immediate assistance, lasting from minutes to hours, but usually taking only one session. Its goals are to provide support, reduce lethality, and connect the person in crisis with other helping resources.

Crisis first aid is designed to reestablish immediate coping, not to finalize psychological resolution of the crisis. In addition, school psychologists, counselors, or social workers provide therapy as part of their counseling activities. This technique, designed for those with formal training in short-term therapy, seeks to finalize resolution by working through the crisis ". . . so that the event becomes integrated into the fabric of life" (Slaikeu, 1984, p. 82). Such therapy, which may last from weeks to months, builds upon the work of Lazarus (1976, 1981) and examines behavioral, affective, interpersonal, somatic and cognitive aspects of the crisis. Its four major tasks address physical survival, expression of feelings, cognitive mastery and behavioral/interpersonal adjustment.

Nelson and Slaikeu offer many suggestions for implementing both methods in the schools. They emphasize the wealth of information that is available through daily contact with the classroom teacher. As have others in regards to adults, they warn that children should be involved as much as possible in solving their own problems. Mastery is fostered as the child is aided in generating their own alternatives, weighing pros and cons, and choosing next steps.

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Current review of theory, research and practice. Includes a comprehensive model for crisis intervention. Discusses psychological first aid (Chapter 6) and crisis therapy (Chapter 8) and gives case examples of each (Chapters 7 and 9). Includes chapter by Nelson and Slaikeu on crisis intervention in the schools (Chapter 16).

18

Best Practices in Crisis Intervention

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OVERVIEW

Crisis intervention skills for school psychologists are becoming indispensable as the numbers of crises in our schools spiral upward. At present all schools are at risk for crises — even "successful" schools in prominent neighborhoods (Jay, 1989).

Although few of us feel completely prepared to face and manage shootings, kidnappings, emotionally out-of-control staff members, or assaults on teachers, the simple reality is that most of will face just such challenges. Government figures for 1985 documented 450,000 violent crimes in our nation's schools and colleges. Assaults accounted for most of the incidents, followed by robbery and rape (Mayfield, 1986). Keen (1989) noted that three million children are attacked at school each year and that weapons were used in 70,000 assaults. A 50% increase has been cited in the number of attacks on teachers form 1973 to 1985, and youth homicide has doubled in the last 20 years (Envoy, 1988). Memmot and Stone (1989) report that one child is killed every day in accidental shootings and 10 more are injured.

In addition to violent crime and accidental shootings, child and adolescent suicide has similarly evidenced dramatic increases. It is difficult to get accurate figures on the incidence of teen suicide, but recent governmental figures indicate that approximately 5,000 young people in the 15- to 24-year-old age group commit suicide each year, whereas only 200 young people under the age of 14 commit suicide. The incidence of teenage suicide appears to have tripled since 1955 and doubled since 1970 according to Vidal (1986). Leder (1987) cited suicide as the second leading cause of death for teenagers. Several researchers have commented on the percentage of high school students who have made suicide attempts. A range of 8.4% to 13.0% was found by Harkavy-Friedman, Asnis, Boe, and DiFiore (1987), Smith and Crawford (1986), and Ross (1985). Gordon (1985) has estimated that 1,000 teens attempt suicide each day. Friend (1988) summarized a study of 11,419 eighth and tenth graders that found that 34% of those surveyed had seriously thought about suicide and 14% had actually attempted suicide. Pfeffer (1986) has addressed the question of what the incidence will be in the year 2000. An increase of 94% is predicted in the 15- to 19-year-old category.

Several years ago the department of psychological services of the Cypress-Fairbanks Public Schools received a phone call from a superintendent requesting that psychologists be sent to the site of an in-school shooting. Precisely what had happened, who was in charge, or how exactly we might improve the situation was completely undetermined. Nothing could have prepared us for what we found:

Television news teams roamed the halls, large numbers of frightened students were unaccounted for, telephone lines were clogged with frantic calls from parents, teachers were rattled from the near hysteria, and administrators felt ill-equipped to manage the barrage of problems that fell upon them in the course of a fleeting moment. It was generally felt that a psychologist ought to know what to do with an incident that carries with it such emotionality. Those of us who approached the scene, however, felt the same sense of helplessness, anxiety, and confusion.

Since administrators frequently see school psychologists as the experts in this area and since we may be the only school personnel trained in the management of strong emotions and preventive program planning, it is logical that the responsibility for crisis intervention fall squarely on us. Our profession, however, has been slow to prepare us to fill such a role or to be proactive in establishing and organizing crisis intervention activities in the schools (Smead, 1985).

This chapter will outline a practical model for crisis intervention in the schools that will enable school systems to organize and respond effectively in the face of a crisis. The role of the school psychologist ranges from that of manager to trainer to program planner. The overall model first establishes competent reaction to crises, then presses on to establish competent prevention of crisis. It is our intent to pass along the information we have accumulated in nearly a decade of research and management of school crises (Pitcher & Poland, in press).

BASIC CONSIDERATIONS

Probably the most pronounced characteristic of a crisis in the schools is the intense emotional upset or "disequilibrium" experienced by the system. Much as in personal crises, staff members experience feelings of helplessness, denial, inadequacy, and confusion. If the crisis is not resolved, depression or burnout, physical symptoms, and disorganization of functional working relationships occur. It is for this reason that school psychologists are frequently seen as the most appropriate personnel to intervene and support staff in crises.

In inexperienced or unprepared districts, however, psychologists are typically summoned at the least advantageous moment. Traditionally, crises have been regarded as unfolding in four stages: First, there is an initial rise in tension due to the crisis event. Second, in the face of the continued impact of the stressing event, there is a lack of success in the usual problem-solving techniques. During the third stage other problem-solving resources are mobilized, and, following failure of these, tension mounts to the breaking point during the fourth and final phase of severe emotional disorganization (Caplan, 1964). All too often school psychologists are called during the last portion of the third or fourth phase. It is of necessity, then, that we develop the arsenal of skills required to restore emotional organization at this time.

There is, however, a second and very significant aspect of crisis in the schools that we must prepare ourselves and our profession to embrace. During and just subsequent to crisis there is a reduced defensiveness or increased openness on the part of the system, again paralleling personal crisis. Crisis has been frequently recognized as a time of potential danger as well as potential opportunity (Wilhelm, 1967; Lidell & Scott, 1968; Slaikeu, 1984). If our profession is able to manage the danger, that is manage the immediate crisis and quickly return the system to normal functioning, then there exists a tremendous opportunity to stimulate long-term systemic change. Once seen as effective and credible, the psychologist has infinitely more opportunity to move the system in the direction of prevention. Thus, the general intent of our approach is actually two-fold: (a) To establish crisis management procedures that support effective coping/management behavior during extreme emotional states (which will return the system to normal functioning as quickly as possible), and (b) To introduce crisis prevention activities that

will reduce the probability that the crisis will recur.

As in public health, our concept of prevention can take three forms: primary, secondary, and tertiary prevention (Bloom, 1977; Caplan, 1964). Primary prevention includes activities that prevent crises from occurring altogether, secondary prevention includes activities that arrest potential crises from escalating, and tertiary prevention aims to repair damage from the occurrence of a crisis (i.e., crisis management). By way of illustration, then, primary prevention might be educating elementary school teachers about custody laws and establishing school policies and procedures to regulate authorized removal of children from the school. Effective implementation of such safeguards would constitute secondary prevention, and competent management of a crisis in which a child has been removed from school by an unauthorized person would be tertiary prevention.

School psychologists who have been trained in organizational and community intervention will quickly recognize primary and secondary prevention as the mainstay of most systems-level intervention (Danish and D'Augelli, 1980; Rappaport, 1977; Reiff, 1975). However, school administrators usually are infinitely more amenable to primary or secondary activities once they have found themselves face to face with the tertiary prevention problems of managing a crisis. In reality, therefore, school psychologists are frequently faced with the somewhat illogical approach of beginning to intervene at the tertiary level of crisis management, and only later focusing on primary and secondary activities. Enter the tremendous opportunity for school psychologists in crisis intervention.

Administrative personnel who have managed an intense crisis are far more motivated to avoid having to do so again. Frequently this phenomenon occurs at the highest levels of administration and the school board. These officials are scrutinized by the entire community for making the right decisions under pressure. The question rises from parents, children, the media, and faculty: What's being done? Districts that can answer this question most convincingly and reassuringly are the ones that have planned activities and procedures along all three avenues of prevention, as stressed by the present model.

BEST PRACTICES

Developing a District Program for Crisis Intervention

Nelson and Slaikeu (1984) pointed out that crisis intervention needs to be included in the job descriptions of school personnel such as administrators, counselors, and school psychologists. Guetzloe (1988) emphasized that educational associations are recognizing that more needs to be done in preparing schools to deal with a crisis. Guetzloe pointed out that California in 1982 mandated that schools be safe and stressed the following points: (a) Teachers and administrators should be trained in crime prevention and safety procedures. (b) School security engineers should approve of school construction, and schools have a responsibility to keep students safe.

Historically attempts to prevent a crisis from occurring at school have concentrated on evacuation procedures such as fire and natural disaster drills. The incidence of violence in our schools and society indicates that we have to prepare for violent behavior. As one teacher put it, "We have to be prepared for violent intrusion from an outsider or violent behavior on the part of a member of our school."

An examination of a number of school district procedures on crisis intervention is enlightening. Most procedures address chain of command issues such as when to call the superintendent or security and whether to evacuate the building in the event of a bomb threat. These organizational issues are certainly important, but a crisis team that can provide a range of services is needed.

There is little information about exactly how crisis teams are organized.

Ruof and Harris (1988) described three options in setting up a crisis team:

1. An inside model that includes only staff from one building on the crisis team.

2. An outside team composed of community mental health professionals or itinerant school personnel such as school psychologists and special education personnel.

3. A combined model utilizing building personnel and professionals who do not regularly work in the building.

Ruof and Harris pointed out that there are many advantages to the inside team format, because students know the team members and they are more immediately available. A disadvantage may be that a building may not have the necessary personnel or the personnel may not have crisis intervention skills. In contrast the outside model utilizes more trained personnel, but they do not know the students and must be called to the building. One outside crisis team reported to us that they were ready to assist in the aftermath of a student death but the principal did not call on them. Pelej and Scholzen (1987) and Schulman (1986) have cautioned against having the school system always call in outside experts when a crisis occurs. And Ruof and Harris cited two additional problems with this approach: There may not be enough itinerant school personnel to call on, and outside professionals may be too costly. However, Comstock (1985) stressed that outside mental health professionals are willing to assist at little or no cost if the school system will involve them in a meaningful way and listen to their recommendations. All in all the combined model is recommended by Ruof and Harris, because it utilizes personnel in the building who know the students and the expertise of itinerant school personnel or community mental health personnel.

The size of a particular school district and the availability of resources are important factors in developing a crisis team. It is recommended that small school districts use the combined model with emphasis on assistance from area and community mental health specialists. A large school district should utilize a combined model but will probably not need assistance from professionals outside the school system.

Selecting crisis team members is very important. Ruof and Harris (1988) recommend that membership on the crisis team be voluntary. Team members should not only be willing but should have attributes and skills that will enable them to perform well. The question of how many school personnel should be on a crisis team was discussed by Ruof and Harris, who recommended a minimum of two persons and preferably one team member for every hundred children. We recommend that teams be composed of four to eight members. A team approach is needed because no single person can do everything. Principals have commented that they could not be in the four or five places they need to be at the same time during a crisis.

Theoretical Model

Crisis team members need to be familiar with Caplan's (1964) model. Most people think of crisis intervention only as what is done in the immediate aftermath of a crisis. The most important issue is what can be done to prevent a crisis from happening. One principal who experienced a shooting at school feels very strongly that students must not keep a secret about life-threatening behavior. Many efforts have been directed towards improving and maintaining close communication between faculty and students. Too often students know about potential crisis events but keep the information to themselves.

It is not possible to specify all the *primary prevention* activities that a crisis team could be involved in. Examples are high schools that decide to do something about drunk driving by establishing a safe ride program and working to prevent teen suicide by establishing a school crisis helpline. On one occasion the students of a local teacher who had rehearsed a "secret signal" of danger with her class followed her cue and violence was averted

when a gunman entered her class. The types of questions that crisis teams need to think about to prevent a crisis are:

1. What is worrisome about the school or the neighborhood?
2. Is there a potentially violent student or parent?
3. How could we notify students to stay away from windows or to evacuate the playground or the school quickly?
4. If we evacuate the school, where do we go?
5. What has worked or not worked to handle a crisis situation in the past?
6. Is all playground equipment safe?
7. Do school personnel know CPR and first aid? Who will summon medical assistance? What if the nurse is not available?
8. How can a teacher summon help from the office?
9. Does the school offer a gun safety program?
10. Is the school system prepared to deal with the media?
11. Have school staff been provided with information on how to deal with a violent person?
12. What communication systems are available to contact police and to inform the superintendent of schools?

Dillard (1989) made these additional recommendations for primary prevention:

1. Know how to call on mental health resources in your community.
2. Establish close cooperative relations between the school system and police and fire departments.
3. Be prepared to provide ongoing assistance to students, their parents, and school staff after a crisis. Group meetings held at school can convey factual information and dispel rumors.

Many issues concerning safety also need to be addressed in the curriculum. One of the most important involves educating students about gun safety. Ten children each day under the age of 18 are killed in handgun suicides, homicides, or accidents (Memmot, 1989). One school system that is educating its students about gun safety is Dade County in Florida. Doup (1989) reports that the program begins in the first grade and is modeled after drug prevention programs.

The *secondary level* of intervention in Caplan's (1964) model emphasizes responding quickly to minimize the chance of long-lasting effects to a crisis. School buildings may want to form medical emergency teams and rehearse their response to various situations. Control of students is also very important. Plans need to be developed to direct students to classrooms or out of the building without mass confusion. One high school crisis team has made evacuation arrangements with local churches near the high school campus; the team also has ready a "crisis box" with materials that would be needed in the event that the school needed to be evacuated. The school faculty must also be told promptly when a crisis occurs. Thought needs to be given to how to accomplish that. The faculty needs to process the crisis event and their feelings about it as soon as students have gone home. This meeting to process the event can also be used to plan for the next school day.

Contacting law enforcement personnel is also part of secondary intervention. Which law enforcement personnel will be called and what to expect when they arrive are important questions to be addressed. Parent contact is also very important. The parents of injured and upset children need to be contacted. Parents may simply appear at the school and they might be upset and make demands upon the school or they might have come to help out. One crisis team elected to involve parents in a positive way. They contacted parents who lived near the school and who were home during the day and made them a part of their crisis team. Communication to

parents after a crisis is very important. It is important to clarify how this communication will take place and who will do it.

The emotional effects of a crisis must also be dealt with immediately in order to minimize long-lasting debilitating effects. This point is well illustrated by Sandall (1986), who not only discussed immediate steps taken in the aftermath of a school bombing in Cokeville, Wyoming, but contrasted actions taken there with those taken in Chowchilla, California, in the 1970s. A school bus full of children was kidnapped in Chowchilla and was sequestered in the desert for several days. The children escaped and were physically unhurt. Sandall reports that the Chowchilla school children were told to go home and forget about the incident, and it was felt that only a small percentage of them would suffer permanent psychological effects. A follow-up study 5 years later found 100% with psychological problems as a result of their experience. By way of contrast, Sandall describes the steps taken in Wyoming to provide opportunities for children and faculty to discuss their feelings. School was held the day after the bombing and all who could be released from the hospital were encouraged to attend. Sandall commented, in part, "Those children who verbalized most effectively and in the greatest quantity have managed recovery best" (1986, p. 2). Children who have witnessed a traumatic event commonly react, according to Pynoos and Eth (1986), by (a) reexperiencing the event mentally, (b) fearing that it will happen again, and (c) withdrawing from the outside environment and clinging to family members.

Schulman (1986) discussed immediate steps taken in Concord, New Hampshire, to deal with emotionality following the Challenger shuttle disaster that killed Christa McAuliffe, a teacher at the high school. Schulman emphasized that having a crisis team already in place was of great benefit. Students and teachers were provided many opportunities to express their emotions and given flexibility with regard to their schedule and movement around the building. Students had a number of choices. They could go to the gym and vent frustrations and anger through physical activity, they could go to the cafeteria to support and be supported by others, or they could go to the library, which was a quiet wake area.

Tertiary prevention involves the long-term follow-up of those affected by a crisis. Sandall (1986) stressed the need for tertiary intervention and pointed out that counseling was provided over the summer in Cokeville, Wyoming. Follow-up questionnaires are also recommended. School psychologists are in a position to provide follow-up and monitoring to those most affected by a crisis. If we cannot provide the long-term assistance ourselves, we can recommend that the family seek it privately. Anniversary dates of losses and crisis events are important.

Training Issues for Crisis Team Members

Team members need first of all to be able to recognize a crisis, which Jay (1989) pointed out is an event that is likely to (a) interrupt normal routine and escalate in intensity, (b) draw attention to the school and jeopardize the school's image, (c) interfere with student's and staff's ability to focus on learning. Smead (1985) discussed the importance of responding immediately to a potential crisis to minimize its effects. The crisis team should meet if at all possible even if the event does not seem to be of crisis proportions. What this immediate response should be was emphasized by Slaikeu (1984), who outlined the following principles of psychological first aid:

1. Make contact with the victim and give him/her permission to express thoughts and emotions.
2. Explore the problem in terms of the past, present, and future.
3. Identify possible solutions to assist victim.
4. Take definite actions to assist victim.
5. Provide follow-up assistance.

Psychological first-aid addresses immediate concerns and helps the victim sort out such needs as welfare, safety, shelter, and so forth. Ruof and Harris (1988) recommend that team members receive as much as 30 hours of training.

One District's Approach

The development and implementation of a district crisis intervention plan was assigned by the superintendent to psychological services. The following steps were taken:

1. The literature was surveyed and a few crisis plans from other school districts were located.

2. Principals were interviewed to get their input and to involve them in the process.

3. Directors of security, nursing, transportation, and public information were all interviewed.

4. A building crisis team approach was recommended with district personnel involved in a support role.

5. Building principals were designated as crisis coordinators and the media spokespersons. An in-service was provided to clarify their role.

6. Principals designated liaisons in the following areas: counseling, law enforcement, student, parent, campus and medical. These liaisons together with the principal formed the building crisis team. Training was provided to the various liaison roles.

7. Principals were provided with training on dealing with the media; emphasis was placed on being cooperative but also containing the media.

8. District transportation personnel received training.

9. A tip sheet for teachers and aides for dealing with a crisis was developed and presented at an in-service in every school building. Teachers were encouraged to make plans to deal with such behavior as tantrums, fights, running away, and medical emergencies. A worksheet to address these problems was provided.

10. A basic premise was emphasized that these steps were only a starting point and that the most important recommendation was for the building crisis teams to meet regularly and discuss their school.

11. Crisis intervention activities were publicized and shared with the community.

Crisis drills. The district had on paper an excellent crisis plan, but to make crisis intervention an integrated part of the school regimen more steps had to be taken. The superintendent authorized conducting crisis drills and gave the principals forewarning. A script for the initial crisis drill was written and various central administrators went to the scene to role-play the crisis. To minimize school disruption the crisis drill took place outside the school building. A sample crisis scenario appears below.

> *Incident:*
> A female student has been shot in the foot by a pistol in front of the school by the flagpole. The pistol, which she was carrying in her purse, discharged with students nearby. Your first notification of the incident is when several hysterical students rush into the office. The student has a younger brother who attends the same school. The superintendent's secretary will role-play the mother; please call her.
>
> *Task:*
> Please respond to this incident following the district crisis intervention procedures. District personnel are on the scene to role-play and ask questions. This is a ***practice drill*** and district personnel should be alerted; however, it is *not necessary* to notify agencies outside the district.

Verbal and written feedback were provided to the crisis team. The importance of a team effort was stressed, along with indications of prior planning. The first two drills were videotaped and were shown at the principals' meeting. Numerous drills have since been conducted, including even a surprise crisis drill at the

central office. No one has complained about the crisis drills, and they serve the purpose of making crisis intervention a regular part of conducting school.

DEALING WITH DEATH

Stevenson (1986) pointed out that one of every 750 young persons will die each year. The most frequent causes of death for school-age children in order of magnitude are accidents, suicide, and homicides. School crisis team members need to be trained to assist in the aftermath of a death. Verification of a death is essential. A second or third verification needs to be accomplished before the death is announced. The principal is the logical person to direct the crisis team and to announce the death. Fitzgerald (1988) makes a number of recommendations in this area: (a) Announce the death over the intercom so that everyone gets the same information; then visit as many classrooms as possible, especially those most affected. (b) Provide opportunities for discussing emotions, going through the grief process, and funeral arrangements. (c) Send a letter home to parents that gives information about the death and how parents can help their children. (d) Counseling grief groups may need to be provided on an ongoing basis.

Educators often expect all children to react to a death in the same way, the typical expectation being that children should cry. Children should be given permission for a range of emotions. The child stating he doesn't care today may cry tomorrow. Crabb (1982) suggested the following classroom guidance activities to assist students: (a) unfinished sentence writing; (b) drawing a picture to express feelings; (c) using music to express thoughts and emotions.

Do not rush to remove desks and personal possessions of the deceased. Involve students in that process and encourage students to contact the family of the deceased in person or through cards and letters. It is recommended that a school psychologist follow the class schedule of the deceased. Stevenson (1986) recommends minimizing religious platitudes or symbolism and advises that there is no correct response to a death. Physical contact may comfort some students. Students may be flooded with waves of emotions. Their individual life histories will influence their ability to cope with the death. Stevenson states that it is appropriate to just let students sit but not to leave them unsupervised. The most common reaction is shock as students try to grasp the finality of the loss. It is important that all school personnel model expression of emotion; curriculum concerns may have to be set aside.

Oates (1988) recommends a model to determine the expected degree of trauma following a death: The popularity of the person who has died and his or her length of time at a particular school are determinants. The circumstances of the death are also important. Suicide or murder result in more trauma than death by natural causes. A death that occurs at school also results in more trauma. These factors that address who, how, and where are very relevant to dealing with death.

Team members will need to be advocates for giving schoolchildren and staff the opportunity to express their emotions. This point is illustrated by the following comments of a teacher whose classroom had been bereaved.

> "I heard about the murder of R, a seven-year-old girl in my class, the night that she was killed. I went to school early the next morning. My principal was just moving her desk out of my room. The principal said that all of her possessions had been removed and that I should avoid talking about her murder and concentrate on academics. I was angry and so were my students; we all felt robbed of a chance to express our emotions and to say our farewells to her. One student asked if we couldn't at least let a balloon ascend to heaven in her memory. I allowed that and it helped her classmates."

Crabb (1982) emphasized that children's emotional problems after a disaster continue until help is provided. Children need to be provided the facts in age-appropriate terms, and rumors must be

dispelled. Dillard (1989) recommended providing parents and children the opportunity to be together and share experiences after a tragedy. Dillard described meetings that were held over the summer following a shooting in Winnetka, Illinois. These meetings helped children achieve mastery over the shooting. Dillard stressed that a traumatic event is stored in active memory until mastered. Details fade from immediate memory when mastery occurs.

Developing A Suicide Intervention Program

Youth suicide has many implications for the schools. Legislation has passed in five states that addresses the role of the school in prevention. Most states are studying the problem of youth suicide. No national legislation has been passed, although a national conference was sponsored by the federal government in 1985. The question of the responsibility of the schools with regard to youth suicide is not a new one. Stekel, a social scientist, commented on an outbreak of youth suicide in Europe in the early 1900s: "The school is not responsible for the suicide of its pupils, but it also does not prevent these suicides. This is its only, but perhaps its greatest sin" (quoted in Peck, Farberow, & Litman, 1985, p. 158). Few schools are prepared to deal with youth suicide and very few policies and procedures have been written to clarify the role of school personnel (Harris & Crawford, 1987). Ross (1985) stressed that it is fear and not lack of concern that results in school administrators' reluctance to work on this problem. Few school administrators have received any formal training in suicide prevention. They hold many misperceptions about youth suicide and see it as a problem that happens elsewhere. School prevention programs began in California in the 1970s and have spread by a grassroots effort, each school reinventing the wheel (Ryerson, 1988). School psychologists are in a position to clarify the schools' role and write policies and procedures to work on this problem. Several writers have emphasized that intervention programs in the school are effective (Cantor, 1987; Ross, 1985; Ruof & Harris, 1988).

Case example. A high school English teacher read a theme that a ninth-grade girl had written that made many references to hopelessness and nonexistence. The teacher asked the girl to stay after school in order to directly inquire about how things were going for the student. The girl shared many family, school, and romance problems that were bothering her. The girl stated, "My life is hopeless and not worth living." The teacher told her that help was available and that the teacher cared. The teacher escorted her to the school counselor's office. The school counselor spent a lot of time establishing rapport with the student and gathering a careful case history.

The girl had attempted suicide 6 months previously by taking aspirin. She had become ill but told no one what she had done. Her aunt had committed suicide by carbon monoxide poisoning and she planned to utilize that method next time. She had carefully thought out when she could go into the garage without being detected and had imagined how others would react to her death. The school counselor called the school psychologist for assistance. The girl signed a no-suicide contract and was told that her parents would be called and that this was in her best interest and in accordance with school policy. She was told that many other students had been helped and that the school psychologist and counselor would solicit a supportive reaction from her parents.

The parents initially refused to come to school. When they did arrive, they were angry at their daughter for not telling them about her suicidal thoughts. A referral was made to a private practitioner who had experience working with suicidal teenagers. The parents were provided with specific suggestions about supervision and support of their daughter. A follow-up appointment was made at school with the student and the school counselor. The principal was informed of the situation and the referring teacher was complimented on her role. The girl was moni-

tored closely over the next several years. She never attempted suicide again. Shortly before graduation she stopped in and thanked her English teacher for helping her. The student stressed that her life wasn't wonderful but she was glad to be alive.

Forces and factors in youth suicide. There are numerous forces and factors that school psychologists need to be aware of. These are outlined in detail by Poland (1989). A precipitating event may cause a young person to act on suicidal thoughts, the most common precipitating events being arguments with parents or with boyfriends or girlfriends, or the loss of a loved one (Eyeman, 1987; Porter, 1985). Shaffer (1988) stressed that discipline incidents and loss of face with peers are also factors.

Depression has long been considered the most important warning sign of suicide. Numerous researchers stress that depression in children does exist but does not account for all youth suicides. Adolescents with conduct disorders are also at risk of committing suicide (Eyeman, 1987; Shaffer, 1988).

Use of controlled substances is now known to play an important role in youth suicide. Substance abuse can cause a young person to lose contact with reality, increasing the chances of a suicide attempt. Alcohol and many other drugs are depressants, which only add to psychological problems. Davis, Sandoval, and Wilson (1988) suggest that substance abuse be added as a major warning sign of suicide.

Student runaways also may be at risk for suicide. Researchers have found that runaways attempt suicide approximately 20% of the time (Engleman, 1987; Fortinsky, 1987).

How children develop their concept of death is important. The young child may view death as something that is either reversible or only happens to the very old (Davis, 1985; Pfeffer, 1986). Adolescents may also have some misperceptions about the finality of death. Young children who talk about life-threatening risk-taking behavior need to understand the possible fatal consequences. School psychologists should inquire as to the beliefs that the suicidal young persons have about death. Youths who have spent lots of time imagining the reactions of others to their suicide may be at high risk of committing suicide (Davis, 1985).

Much of youngsters' suicidal behavior is attention-getting and manipulative. Barrett (1985) stressed that parents need to recognize such behavior means their children want something to change and parents should let themselves be manipulated until they get professional help.

Other factors that may greatly influence a particular child are the following: (a) suicidal statements or suicide attempts by a parent, (b) motion pictures that deal with suicide, (c) suicidal lyrics in songs, (d) news coverage that glamorizes or mysticizes a suicide.

There has been a dramatic change in the methods employed to commit suicide by young people. Females are increasingly committing suicide by using guns. Lester (1988) stressed the strong correlation between gun ownership and suicide and reported that guns are involved in approximately 60% of all suicides. School psychologists will be in a position to address availability of guns with young people and their parents. Many researchers have pointed out that reducing availability of the guns will reduce suicides.

There is no single factor or cause that explains youth suicide. Siebel and Murray (1988) have stressed that there may be as many as 28 factors or causes. School personnel need to be aware of these factors; if they are at all concerned about a particular student, they need to inquire further.

The school's role in suicide interventions. Every school system needs a written policy to clarify the school's role in suicide intervention. These procedures need to address the three levels of intervention outlined by Caplan (1964). Vidal (1986) stressed that help for a suicidal student is contingent on school personnel knowing the policy. The obligations of the school at a minimum are the following: (a) to detect suicidal students, (b) to assess the

severity of their suicidal symptoms, (c) to notify parents, (d) to secure the needed mental health services and supervision for the student, and (e) follow-up at school.

Detection. All school personnel including bus drivers and aides need information on the warning signs of suicide as identified by the American Association of Suicidology (1977). These warning signs include the following verbal and behavioral clues: (a) suicide threats or statements (b) an attempt at suicide, (c) prolonged depression, (d) dramatic change of behavior or personality, and (e) making final arrangements. School personnel should be encouraged to reach out to help suicidal students and should follow district policy in referring students. School personnel *must not* keep a secret about suicidal behavior. They need to understand the situational nature of youth suicide and should clearly feel that they could save a life, as in the case example.

Assessment. Someone in every school system must be skilled at assessing the severity of a suicidal student's symptoms. The most logical personnel to do this are school psychologists. Preparation is required in advance to work through personal issues and perceived inadequacies in this area, and to investigate the various suicidal assessment scales. It may be advisable to rehearse with a colleague or even a drama student.

There is no single scale or set of questions that is recommended for use with a suicidal student. Davis et al. (1988) reviewed the available instruments and noted the following instruments as the most promising:

1. The Hilson Adolescent Profile, developed by Inwald, Brobst, and Morrissey (1987)

2. The Suicidal Ideation Questionnaire, developed by Reynolds (1987)

3. The Suicide Probability Scale, developed by Cull and Gill (1982)

Davis et al. cautioned that more validation needs to be done with all three instruments. But Hoff (1978) questioned the effectiveness of lethality assessment scales and instead stressed communication and the establishment of rapport with the student. Barrett (1985) has emphasized the importance of carefully gathering information from the student to guide actions and pointed out the distinction between assessment and prediction, and McBrien (1983) has emphasized that practitioners must stay calm and ask a series of questions as if the student is planning a trip.

The need for direct inquiry into suicidal thoughts and plans is essential. The need for a careful case history and thorough inquiry into the suicidal plans and actions is outlined through sample questions by Poland (1989). A number of suicidal assessment scales classify students into the categories of low, medium, and high risk for suicide. School psychologists must be careful not to categorize a student as at low risk on the basis of their own need rather than information gathered from the student. No-suicide contracts help students take control over their suicidal impulses and reduce the anxiety of both the students and the school psychologist (McBrien, 1983). Contracts should not be used in isolation (Barrett, 1985). Students who refuse to sign a no-suicide contract should be supervised until parents can pick them up; hospitalization may be needed.

Parent Notification

Parents must be notified any time that it is believed that a child is suicidal. The question is not whether to call them but instead what to say to them. The goal of notifying parents is to safeguard the welfare of the student, but it also serves to protect the psychologist from liability.

Slenkovitch (1986) has stressed that schools should never take a suicide threat lightly. School districts and school employees have been sued for inadequate suicide prevention programs. Davidson (1985) and Henegar (1986) addressed the question of liability, stressing the importance of duty to care and foreseeability of the actions of a client and that the primary issue is negligence. Henegar commented in part: "A negligence theory

in a suicide case is not generally a claim that one caused the suicide but rather that one did not take reasonable steps to prevent it" (1986, p. 14). Henegar made several recommendations that have implications for school psychologists treating suicidal students: (a) increase supervision of the student, (b) limit access to self-destructive instruments, (c) obtain psychological treatment.

Once their parents have been notified, most suicidal students are relieved that their parents now know what has been on their mind. Parents' reactions may range from extreme cooperation to extreme denial and anger at the school. A common initial reaction of parents is hurt that their child is thinking of suicide. Johnson and Maile (1987) recommend that parents do the following: (a) Be patient, show love, and seek out the help their child needs; (b) take threats and gestures seriously; (c) keep communication open and get help with no strings attached.

The challenge to the school psychologist is to notify parents in a way that elicits their support and to convince the parents to obtain the needed services for their child. Stanton and Stanton (1987) stressed the point of finding parental strengths and empowering the parents with the belief that their child can be helped. However, it is advisable to document notification of parents and to have two school personnel present at the conference during which parents are notified. A resistant parent should be asked to sign a form acknowledging that they have been notified of their child's suicidal state. Parents who refuse to follow through on a recommendation for treatment services in the community must be told that it is neglectful not to get treatment for a suicidal child and that school personnel will call the child welfare department. A resistant parent might forbid the school psychologist to talk with their child. Some states, such as Texas, have passed legislation that allows psychologists to provide services to a suicidal minor without the parents' permission.

Working with suicidal students causes anxiety. Brown and Schroff (1986) recommended that school psychologists take care of themselves by getting the opinion and support of others and processing feelings and by recognizing that no one can assume the responsibility for the life of an individual who is threatening suicide.

Community services. School psychologists should not accept the primary responsibility of treating a suicidal student. They need to be familiar with community resources to assist suicidal students and should establish a cooperative relationship between the school, the parents, and the community mental health provider, so that maximum support is provided to the student. However, they need to continue to provide support and monitoring at school even though the student is receiving community services.

Postvention. Schools are not usually prepared to deal with the aftermath of a suicide. Experts have emphasized that a series of planned steps must be accomplished to minimize the chances of a second suicide and to help students and faculty deal with their grief (Kneisel & Richards, 1988; Lamb & Dunne-Maxim, 1987). Policies designed to meet these needs must be in place prior to a suicide. Numerous writers have emphasized that suicides must be acknowledged and talked about (Biblarz, 1988; Ryerson, 1988). Normal procedures in the event of a death should be followed with an emphasis on avoiding a dramatic, romantic, or mystic treatment of the suicide. The task facing most school survivors is resolution of grief. Homeroom discussions should provide an opportunity for students to express their grief. Individual and group counseling needs to be provided at school (Coleman, 1987). Lamartine (1985) pointed out that the suicide of a student increases the probability 300% that a second suicide will occur. School psychologists need to identify other students who are at risk of committing suicide and provide assistance to them. Everyone at school needs to know the warning signs of suicide and to feel empowered to prevent further suicides. The following additional recommendations are suggested after a student suicide has occurred.

1. The suicide should be acknowledged and school activities should continue.
2. The faculty should be assisted first, then students.
3. The family of the suicide victim should be contacted to express condolences and to request the funeral be during non-school hours.
4. Memorials to the student who committed suicide should be downplayed.
5. Media coverage of the suicide should avoid front page coverage and should downplay simplistic explanations and avoid details of the method employed. Prevention information and community resources available should be included.

Curriculum issues. Curriculum approaches to suicide prevention fall into two categories. The first approach emphasizes a positive school climate, affirms life, and promotes life skills, especially problem solving, for the students (Sowers, 1987). All professionals agree with the importance of this approach. The second approach involves directly talking in the classroom about suicide as a mental health problem (California State Department of Education, 1987): Classroom presentations stress the warning signs, befriending skills, intervention by friends, and the situational nature of suicide. Also included are the relationship between suicide and use of controlled substances and the community services available to help a suicidal youth.

There is debate about whether the curriculum approach is to be recommended. Shaffer (1988) called for a moratorium on such curriculum presentations and noted that they were developed because the schools felt a need to do something. Smith (1988), commenting on Shaffer's research, noted that most students who participated in curriculum programs viewed them positively. The central point of controversy seems to be the contention that curriculum presentations somehow plant the idea of suicide. This premise is at the basis of Schafly's (1985) objections. A very logical question arises: Can teenagers translate information presented to them into life-saving behavior. Numerous evaluators have said yes to this question.

The question of whether parental permission should be obtained before a student participates in a curriculum presentation has been raised as well as the relevance of the Hatch Amendment (Davis et al., 1988; Schafly, 1985). Florida requires parents' permission, for example; California does not. A very unfortunate consequence of the curriculum debate is that many school districts have misinterpreted the debate to mean that professionals do not agree that schools need to prepare and take systematic steps to prevent youth suicide. This is not the case. There is no debate about the basic role of the school in detecting and assisting suicidal youth. School psychologists should be involved in determining the need for curriculum presentations in their district and selecting materials if presentations are to be provided to students.

SUMMARY

There has been an increase in the number of crisis events that affect the schools. School psychologists are the logical personnel to respond. It is important that school psychologists respond on these occasions to help all concerned and to broaden the role of school psychology. The initial intervention of school psychologists tends to be at the secondary or tertiary level. Among other interventions, it is important that they advocate for opportunities for those who experience a crisis to express their emotions. In addition, the focus of future practice by school psychologists needs to be on primary prevention activities in the schools.

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The role of the school is defined, and case examples provided step-by-step guidelines for setting up and maintaining a comprehensive program. Issues covered include the following: forces and factors in youth suicide, assessment, parent notification, liability, legislation, curriculum, and dealing with the media. Detailed procedures for intervention following crises.

Crisis Response Teams a Must for all School Districts

by Al Neuhaus

People in crisis often experience anxiety, feelings of vulnerability and difficulty. Events such as sudden death of a teacher or student, natural or accidental disasters and real or threatened violence may produce a crisis for students and faculty alike. Most school personnel have had little or no previous training or experience in working with a grieving person or coping with a crisis in the school setting. Past experiences have taught us that educators need guidelines, support and established procedures for managing crisis situations.

After experiencing a high level of anxiety out of concern for the aftermath of a suicide at the junior high level, it was with enthusiasm that I accepted the invitation to be a part of our soon to be developed crisis response team in 1988. Even in our rural district of 6,500 students I had felt for several years the need for a crisis response team and finally it was happening with the impetus coming from our superintendent. Fifteen of us were selected – another school psychologist, guidance counselors, school nurses, teachers and other specialists from both the elementary and secondary schools. We met for a day and a half in December 1988 with Dr. John Dudley, a regional expert on crisis team training and an administrative assistant with the Lincoln, Nebraska public schools. Our first task was to make sure each of us individually was prepared to handle death and the grieving process.

Our team defined a crisis in our district to be: the sudden death of a teacher or student, a natural or accidental disaster, and real or threatened violence. It is important for each district to determine what it wants its team to respond to based upon the community and school resources. We decided to divide into two teams so one team was on call at all time. We learned that the primary key was preparedness. We developed and borrowed operational guidelines and a crisis response checklist that fit our district. When the time came we knew who and how staff would be notified, who would handle the media, what the responsibility of building level staff would be, who would notify the attendance secretary and who would see to the daily routine activities. We knew that the crisis team would meet with the building principal to plan prior to meeting with all staff (all staff means secretaries, teachers, cooks and custodians) at the first opportunity.

Faculty need to know the facts of the situation to dispel any rumors. They need to know the plans for the day, where the counseling center will be and have an opportunity to express their feelings. We would let them know the kinds of feelings students might express and how they could respond. We would notify all building principals within the district and private schools in the community so they could prepare their own support staffs.

Following our initial training our Crisis Response Team met on several occasions to formalize our plans, to receive hospice training and to gain the expertise of local funeral directors on how to respond to grieving persons. We discovered there are a number of resources in the community willing to provide training as a public service. We developed handouts for faculty and parents and a manual for crisis team members with procedures, guidelines and intervention techniques. In the process of solidifying our plan it happened – we had an eighth grade student involved in a serious car accident on Friday evening, March 31, 1989. As we were informed during our training, verification of death can be difficult to establish. Shannon had received serious head injuries and was transferred immediately to a major hospital out of the community. We eventually received verification of death in the afternoon of April 1.

Our preparation and planning were paying their just rewards. A calling tree was initiated to inform all staff on Saturday that Shannon had died and there would be a faculty meeting before school on Monday. Our crisis team met with the school principal and counselor on Sunday afternoon to plan the forthcoming days. The principal and school counselor made their first home visit. We had ready for Monday a homeroom announcement that teachers could read to their students, a handout for teachers on what they might expect and how they could take care of themselves. We had a parent letter with facts about the funeral arrangements and a handout for parents with tips on talking to their child about death and the grieving process. We had a crisis team member address Shannon's homeroom because there was a substitute teacher on that Monday morning. We had two team members stay at the school throughout the morning to help with grieving students. We had three of Shannon's closest friends accompany the school counselor to clean out Shannon's lockers to then be delivered to the family. (We had been taught to not remove a deceased student's personal belongings without the involvement of classmates; it helps the grieving process.) We had one crisis team member talk to Shannon's second grade brother's elementary class on what they should say to Tommy when he returned to school. The team met with staff on Monday after school to process and get feedback regarding students needing further support. We had team members back at the school on Wednesday, the day of Shannon's funeral, which was a much more difficult day for peers as we had been told to anticipate.

Our preparation had paid off as the principal, staff, and patrons of Westridge Middle School were most appreciative of the Crisis Response Team's support. We have continued to improve our skills and inservice all school personnel on our function and how to better be prepared for the crisis situations. We have since experienced an additional crisis – a seventh grade boy was accidentally electrocuted the day before school last year. The team responded because we were prepared. To date we have not had to respond to the aftermath of a student suicide, and I hope we never do, but I know we can handle it when the time comes.

Al Neuhaus is a school psychologist with the Grand Island, Nebraska Public Schools and the director of the Crisis Response Team.

Crisis Team Can Minimize Traumatic Events

It was just a few tantalizing minutes away from lunchtime last Jan. 14.

Thirty-five Los Angeles High School students were winding up their English-as-a-Second-Language class.

Without warning, one of them, 18-year-old Salvadoran immigrant Oscar Marquez, drew a .22 caliber revolver and jerked it to his temple.

Classmates froze with horror as the normally quiet 11th grader — a loner, friends said — pulled the trigger.

He died four days later without regaining consciousness.

This is the story of how the district, over a three-day period, mobilized its specially trained psychological services teams to cope with students in shock, to ease the emotional trauma in the classroom and to restore calm to the campus.

It might be called The Anatomy of a Crisis.

Gerard A. Gumbleton, a senior school psychologist, remembers it well.

He was alone in the Senior High Schools Division's Psychological Services office when the call came shortly after the shooting.

It was from the district's School Operations office. The message:

There was a crisis at Los Angeles High. It involved a shooting. The crisis team should proceed immediately to the school.

Gumbleton first cleared the visit by telephone with principal Patrick DeSantis. Then he and team member Loretta Van Putten, also a senior school psychologist, sped to the campus. They arrived at 1:15 p.m., and immediately went to the principal's office, where they were joined by Howard Eichinger, field coordinator, Psychological Services, and Harriette Williams and Eugene McAdoo, administrators of operations, Senior High Schools Division.

Strategy Formulated

"Our endeavor was to get the facts straight from the principal, which we did," Gumbleton said.

Eichinger added:

"We went over the statement the principal had prepared to read over the public address system to students and the staff — the first official information on the tragedy — and we gave our opinion."

DeSantis' statement — a brief report on the known facts to that time — was an important element in the developing strategy to alleviate the campus tension.

Said Eichinger:

"By the principal's assumption of leadership, psychological services intervention was started."

It was also an effective weapon for rumor control, another vital link in the calming strategy, he said.

Following the reading of the statement, at 1:45 p.m., Eichinger, Gumbleton, Van Putten and DeSantis went to the teachers' cafeteria, where 29 of the ESL class members had been taken.

Six others, who were in closest proximity to Marquez when he shot himself, and who were believed to be in more serious trauma, were led to empty classrooms for special counseling.

In the cafeteria, the shocked youngsters were bunched in small groups with teachers. DeSantis explained the presence of the psychologists, and left. Only Gumbleton remained. He pushed tables aside and gathered the students in a semicircle of chairs.

"It was extremely quiet — starkly quiet," he said. "Some buried their heads in their arms. Some stared vacantly into space. There was very little speaking or movement."

A Chinese interpreter and Spanish bilingual counselor were brought in because most of the students could not speak or understand English.

"I was with them more than an hour," Gumbleton said. "We discussed how they felt about what had happened. They asked questions. We tried to respond.

"Some talked about gun violence in Latin America. Some had family members who were killed. It was: What do you do about this?"

At the end, "we had the beginnings of a free-flowing group with overwhelming concern for what had happened," the psychologist said.

Said Eichinger:

"This was the beginning of the 'working through' process, which consists of their shock reaction. It intrudes into their thoughts and images.

"So what we did during the next two days was to deal with those thoughts and images. First, we discussed their feelings about them, and then came the final phase of the process — assimilation."

Eichinger recalled;

"The kids couldn't get the sound of the bullet out of their heads ... the choking, the blood, the colors ..."

"It was just like a car accident; it intrudes on everything. Desperately, you are trying to get a perspective ... to get the kids to integrate this event into a more rational perception ... and how it fits into a total life picture."

Eichinger said many questions were raised about their war experiences in Central America (some were recent victims of the violence).

"But this experience, to them, was even more catastrophic. They were saying you're not even safe here.

"We tried to put it all together, to put it all on the table and talk about it."

Fortunately, he said, the ESL class was a receptive group.

Still, it was slow getting underway in the cafeteria discussion, Gumbleton said.

"You have to build up trust and feeling for each other," he explained. "I was struggling with Spanish and they were struggling to understand and be supportive.

"It was a group counseling situation. Only when they got the feeling it was okay to talk as they felt did they do so.

"In slightly more than an hour, we made only a minimal dent in the process of understanding, accepting and proceeding with our idea of life. But we did establish the identity of a caring group. We smiled and cried about a few things."

And as the hour progressed, Gumbleton said, the students' composure improved "because they had identified as a group and began to care for each other."

"When one started to cry, they put their arms around him. There were times when tears welled up in my eyes. It was something that touched us, that hit us all. I had explained that my brother had taken his life much the same way. When I mentioned that, two or three of the kids also mentioned that close friends or family members had taken their lives.

"When I explained how upset I was, it freed them to talk about it."

And when the final bell rang about 3 p.m., he said, "we dismissed the kids with the promise of beginning again tomorrow with the same group."

To shield them from further trauma that Gumbleton said could have resulted from questions by the media or fellow students, they were ushered to waiting buses or it was made certain they went directly home.

Meanwhile, Van Putten and school psychologist George Melikan counseled with six students who had been most traumatized by the shooting and who were being interviewed by the Los Angeles police.

Van Putten stayed with one or two until 5 p.m.

In the interim, Eichinger met with the school's psychological crisis team and coordinated strategy for the second day of counseling.

As a consequence, three bilingual (Spanish) school psychologists and a school mental health worker were added to the combined team and were present when Eichinger convened the group the following morning (Thursday).

It was decided that the most traumatized students needed to be interviewed in a small group setting and that the class as a whole required counseling by psychologists.

Gumbleton and bilingual school psychologist Lupe Villegas worked with class periods three through six in the library. District psychiatric social worker Gil Palacio, assigned to the school mental health program, counseled with parents and staff members. And the school crisis team followed up on specific students.

Noon debriefing critical

Noon was a critical juncture for the crisis teams. At a debriefing session, each member reviewed what had been done thus far, bringing each other up to date.

"We replanned our strategy at that point. It was spontaneous, seat-of-the-pants planning based on available information and what we thought needed to be done.

"It seems we made a hundred decisions that morning on how to respond to the needs of the situation."

Counseling continued from 10 a.m until 3 p.m.

Said Gumbleton:

"The students now were beginning to feel more comfortable with themselves, more free to express their feelings. They were expressing a desire to contact Oscar (Marquez) and his family. They designed cards and wrote notes of support and understanding."

About 2:30 p.m., they formed a circle, holding hands, praying in their own ways.

"They held on for five minutes. They didn't want to let go. They were crying off and on," Gumbleton said.

"At the conclusion, we said good-by. It was very moving. The kids felt very deeply. Everyone wanted to hug Lupe and shake my hand."

On Friday, they met again for the third period class in the classroom, with the chairs in a circle.

Then, a dramatic signal of a breakthrough.

The class voted to rearrange the chairs — to put them back in their regular places. But they avoided Marquez' chair.

"I picked it up and carried it out," Gumbleton said. "Then they carried on with their regular fourth-period class."

Eichinger said, "The kids had progressed to the point where they started to assimilate the incident. They wished to get back to their regular routine.

"Lupe and I left the classroom. The teaching continued. One of the ESL counselors remained as a support sort of thing."

But that wasn't the end of the assignment for the crisis teams.

"We continued to provide support to the staff. We talked with teachers and counselors in the classroom, and worked with individual students, as it was advisable, until Tuesday," Eichinger said.

But by Friday afternoon, he said, the campus was "back to normal."

Mission accomplished.

This article originally appeared in "Spotlight," the Los Angeles School District's Newsletter, and was passed along to the Communique by Carl Totton.

ROLE OF SCHOOL PSYCHOLOGISTS IN CONFRONTING CRISIS

In the recent *Best Practices in School Psychology* (Thomas & Grimes, 1985), the topic of crisis intervention is discussed by Valerie Smead. Smead (1985) recognizes the importance of the proactive professional reaching out to assist students and teachers in need. While the notion of prevention may seem contradictory to the interest in crisis intervention, the professional psychologist can view services delivered to a child in need as preventing future problems. Caplan (1964, 1970) has played a major role in documenting the validity of dealing with people in need to prevent future problems. Smead recognizes the importance of intervening when people are under stress to achieve effective, eventual adjustment.

Before proceeding to review options available to school psychologists in crisis intervention, definitions of critical terms must be established. Crisis intervention has been defined by Hafen and Peterson (1982) as "psychological first aid that enables you to help an individual, group, or family experiencing a temporary loss of ability to cope with a problem or situation." The definition recognizes that, at best, intervention can be only the most immediate interaction that you have with a child in crisis. First aid and long-term care do not necessarily go with each other. Instead, after psychological first aid is delivered, the school psychologist can determine the best strategy for the long-term care of the person in crisis.

Temporary loss of ability to cope with a problem situation may reflect any of a number of issues in the person experiencing crisis. The notion of coping is generally discussed at the same time as the notion of stress. Stress can be viewed in any of a number of ways which will influence the manner in which an intervention is created and implemented. Cox (1978) has defined stress as

> A perceptual phenomenon arising from a comparison between the demands on a person and his ability to cope. An imbalance in this mechanism, when coping is important, gives rise to the experience of stress, and to the stress response. Coping is both psychological (involving cognitive and behavioral strategies) and physiological. If normal coping is ineffective, stress is prolonged and abnormal responses may occur. (p. 25)

Coping represents the strategies by which the person under stress can return to more normal functioning. In a crisis situation, stressors must be addressed. Models that depict the relation of stress and coping in crisis have been proposed in a number of writings. Stensrud and Stensrud (1983) have proposed a model of stress management. This model (see Table 1) is relevant to the school psychologist interested in dealing with crisis issues.

The model depicts the relation between locus of control and the perceptions of the person being effected by any of a number of stressful events. The person under stress is seldom able to logically and consistently evaluate all options to dealing with the problem. Ineffective coping, in other words situations that can escalate to crisis, involves threatening or harmful situations that can be perceived as uncontrollable. "I am helpless" and "I will use defense mechanisms to cope" are two internal verbalizations than can be associated with ineffective coping. In contrast, "I can avoid or escape this" and "I can change myself" represent effective coping responses, according to Stensrud and Stensrud (1983). Although their model is a beginning attempt towards understanding people under stress, the authors have provided a useful perspective in conceptualizing the relation between locus of control and the expectancy of people in reacting to

environmental stresses. The authors argue that ineffective coping can harm the person physiologically (e.g., high blood pressure) in addition to the more psychological impact that is evident to an observer. In this handbook, evidence of the physical harm that can be seen as related to crisis situations will be apparent in some case studies.

Kagan (1983) notes that "the consequences of an event are dependent on the structural readiness of the organism" (p. 192). In other words, the young child exposed to a particular event will often react very differently from the older child experiencing a similar situation. The psychologist dealing with the events that appear very similar for two children must consider many more factors than the immediate circumstances themselves before deciding on strategies for assistance. Age of a child, emotional stability, and past history of coping are all issues that will effect our decisions for professional service.

Maccoby (1983) has argued that the younger the child, "the greater the importance of environmental structure in reducing the child's vulnerability to behavioral disruption under potentially stressful conditions" (p. 220). Events in the environment will indeed have a different impact on children the younger we consider them. Providing structure under potentially stressful circumstances might alleviate or prevent full expression of adjustment difficulties. As we later consider specific might alleviate or prevent full expression of adjustment difficulties. As we later consider specific instances of crisis, note the potential for an intervention early in a stressful situation and the possible impact by modifying environmental structure.

Maccoby also notes that stressful events affect the younger child by causing a greater likelihood of extensive behavioral disorganization. Without the specific experience of dealing with related events and the maturity that often comes with successful past coping, the young child cannot be expected to cope successfully without our assistance. As the child increases in age, coping skills become more established. The parent, with the child's developing age, may function less as a barrier to the experience of stressful events and become a support person among many others, such as peers. As the child achieves adolescence, peers become even more important. The child who has moved away from a school to a new community reacts much differently when he or she is a teenager rather than an elementary school student. Services to children under stress will often work effectively when delivered to the entire family.

The importance of coordinating services to the child and family has resulted in models for dealing with family stresses. In the ABCX model developed by McCubbin and Patterson (1981), the period of crisis is considered to be surrounded by a pre-crisis and a post-crisis period. During pre-crisis, the stressor is considered to interact with both the family's resolve in meeting crises and the definition the family makes of the event. The original version of the pre-crisis model was proposed by Hill (1958). As the stressor interacts with resources and the perception of the stressor, the crisis can then be confronted. McCubbin and Patterson propose consideration of post-crisis variables, which include (1) additional life stressors and changes which make the family's adaptation more difficult; (2) critical psychological and social factors that families can call upon and use in managing crises situations; (3) processes that families can engage in to achieve satisfactory resolution; and (4) the eventual outcomes of family efforts. Thus, the ABCX model pulls together issues of stress, coping, and crisis into one package. As we will discuss later, the authors have developed some assessment instruments than can assist professionals in documenting the stress and coping of family members.

Aguilera and Messick (1974) have listed the differences between the general types of interventions that can be used during a crisis and those used during interventions independent of emergency events. Table 2 illustrates that crisis intervention differs from psychoanalysis and brief psychotherapy in the need for a quick resolution of the immediate crisis. Treatment generally focuses on the present rather than delving more deeply into the past of the individual. Secondly, restoration to a level of functioning that coincides with past functioning is a critical goal or focus. Psychoanalysis and brief psychotherapy are much more concerned with past events at the conscious and unconscious levels.

Table 2

	Psychoanalysis	Brief psychotherapy	Crisis intervention
Goals of therapy	Restructuring the personality	Removal of specific symptoms	Resolution of immediate crisis
Focus of treatment	1. Genetic past	1. Genetic past as it relates to present situation	1. Genetic present
	2. Freeing the unconscious	2. Repression of unconscious and restraining of drives	2. Restoration to level of functions prior to crisis
Usual activity of therapist	1. Exploratory 2. Passive observer 3. Nondirective	1. Suppressive 2. Participant behavior 3. Indirect	1. Suppressive 2. Active participant 3. Direct
Indications	Neurotic personality patterns	Acutely disruptive emotional pain and severely disruptive circumstances	Sudden loss of ability to cope with life situations
Average length of treatment	Indefinite	From one to twenty sessions	From one to six sessions

From D.C. Aguilera & J.M. Messick (1979)

Direct Interventions by School Psychologists

A major function of professional school psychology is the delivery of direct services to children. As Grimes (1981) has stated, school psychological interventions result from a merging of psychological theory and research. Interventions involve the identification of behaviors for change and may focus on a wide range of target behaviors including education, social, and personal problems. The professional psychologist is prepared to provide direct services under a variety of conditions. When those conditions include extreme problems of stress and coping, or crisis periods, expertise of the professional may be less extensive.

Medway (1985) has stated that interventions to children by school psychologists often must be built on little research knowledge. Medway argues that there is a serious gap in the research literature in terms of psychological services to deal with specific treatment issues. Literature on adult problems, while much more extensive, may not transfer to working with children and youth. Because of this gap in knowledge about children, school psychologists must review the broader

literature on social functioning and supportive interventions to develop the basis for any form of crisis assistance.

Spillane-Grieco (1984) has described the role of empathic understanding and positive regard in working with children and parents experiencing one type of a crisis, that of running away from home. Spillane-Grieco acknowledges that economic circumstances and the broader social milieu have an impact on pressures experienced by children in the home. Support that parents can provide often times is influenced by the physical realities of sustaining a family life. When children cannot cope with the environment in the home, whether physical or social, there are methods by which a professional can assess the skills of children and parents in terms of relationships. In some studies ofrunaways, families of adolescents who did indeed leave home had less empathic understanding and postive regard than did families who did not experience runaways. Basic communication skills were practiced incorrectly or not at all in many homes having runaways. School psychologists are critical resource persons, because of their professional status, to families. They more readily than other professionals can assess difficulties experienced by children in coping with demands in their environments. They are also in the position to select additional services for children and their family.

School psychologists, while in a strategic position to provide services to children in crisis, have the choice to respond in a variety of ways to any event. Reynolds, Gutkin, Elliott, and Witt (1984) state that school psychologists operate under specific assumptions that influence the type of intervention they provide. Psychologists can choose to react proactively or reactively to a specific event. Under situations of extreme crisis or emergency, reactive interventions may appear to be the only alternative. Providing a specific direct service may appear to be the only feasibile avenue to assisting a child. Proactive interventions, on the other hand, represent a reaching out of the professional to manipulate circumstances and events that will have a later impact. Many actions of school psychologists will have elements of both proactive and reactive services. The school psychologist who perceives himself or herself as a crisis manager will adopt a proactive attitude committed to influencing the lives of children and teachers and supporting more successful coping.

Another dimension of services to children in crisis is the direct versus the indirect service choice. Direct services involve working with the child or the family to assess events, develop possible strategies for confronting the crisis, and implementing a specific plan of action with long term consequences. The indirect route to service is a feasible alternative also. Consulting with the classroom teacher, school counselor, or community mental health professional, the school psychologist can develop a team of professionals to assist the child or the family in crisis. The growth of interest in consultation services reinforces consideration of the indirect service route in dealing with crisis events.

Reynolds et al (1984) notes that either professional or global interventions can be considered in dealing with the child. During crisis, a specific intervention is warranted if the professional is working to eliminate events or behaviors that contribute to the perceived crisis. For example, the child who is being sexually abused will not be processed by the psychologist for placement into a special education program. Instead, the professional will work, often under mandates for reporting, to directly place that child with professionals who can either remove the child from the home or provide support services to intervene directly with the family.

The options available for intervention in any situation are many and varied. Reynolds et al (1984) propose four dimensions by which to accomplish such evaluations: Acceptability, effectiveness, cost, and treatment integrity. Effectiveness of a treatment approach can be documented through formal evaluation or controlled research. Whether or not an intervention works, of course, is a critical issue for the continued use of that intervention option. The school psychologist is one of the few professionals in the schools trained to conduct ongoing evaluation of treatment effectiveness. Documentation of attempts can coincide with more formal consideration of the impact of an intervention.

Child Psychiatrists Describe Children's Reactions To Disaster

How does it affect a child to watch a parent being raped or murdered? What are the long-term psychological effects on a child who experiences a devastating earthquake? These are some of the events described in a special section on children's reactions to severe trauma in the May 1986 *Journal of the American Academy of Child Psychiatry*.

According to child psychiatrist E. James Anthony, M.D., special section editor, "The lasting effects of disasters on children have been ignored by parents and scientists too long."

Child psychiatrists Robert Pynoos, M.D., M.P.H. and Spencer Eth, M.D. point out that there is a large number of unrecognized children who have witnessed violence and suffer from the after effects of the trauma. For example, in Los Angeles County, dependent children witness between 10% and 20% of the approximately 2000 annual homicides.

The special section shows that children who have witnessed traumatic events:

- Reexperience the event in their thoughts;
- Fear that the tragedy will happen again;
- Withdraw from the outside environment; and
- Show an extreme need to cling to family members.

These are the specific events described:

Cambodian children's massive trauma, including violent loss of family, forced labor and starvation in 1975-79. In a study of 40 of these children who had escaped to the U.S., child psychiatrists found that half had developed serious stress disorders, and that depression was common (J. D. Kinzie, M.D., et al.). These youngsters also reported more distress with school grades, peers and themselves than was observed by school personnel (William H. Sack, M.D., et al.).

A devastating earthquake in Italy in 1980, destroying many villages and killing more than 4000 people. Elementary school children were plagued by the memories of victims calling out to be rescued from the rubble. Psychiatric treatment reduced earthquake fears (Rosemarie Galante, M.A., et al.).

Terrorizing attacks by psychotic parents. For children of psychotic parents, the risk for developing psychosis in adult life is 10 to 15 times that of the general population (E. James Anthony, M.D.).

The Three Mile Island nuclear accident in 1979. Eighteen months after the accident, investigators found that children continued to have a high level of anxiety which was not recognized by their parents (H. Allen Handford, M.D., et al.).

Witnessing the murder of a parent. A child psychiatrist studied 16 children who had witnessed a parent being murdered. Their psychological trauma was often intensified by stressful participation in a criminal trial (Carl P. Malmquist, M.D.).

A pedestrian overpass accident, when more than 100 children watched six boys fall 15 feet to the pavement. A school-based intervention program was successful in helping the youngsters get over the experience (Gaston E. Blom, M.D.).

A prolonged crisis for the American diplomatic communities in Afghanistan and Pakistan in 1978-79, including the assassination of the American Ambassador and the destruction of the American Embassy. In a subsequent child psychiatric intervention program, the majority of the children mastered the psychological effects of the trauma through repetitive narrations, drawings and play (Elmore F. Rigamer, M.D.).

The special section points out that we know much less about children's reactions following trauma than we do about adults' reactions. Child psychiatrists Robert S. Pynoos, M.D., M.P.H. and Spencer Eth, M.D., describe a new approach for interviewing the child who has witnessed an extreme act of violence. Norman Garmezy, Ph.D. provides a critique and commentary.

Most of the authors are child psychiatrists and members of the American Academy of Child Psychiatry, headquartered in Washington, D.C. The Academy has 3200 members, who are physicians with 5 years of advanced training in general and child psychiatry. In addition to publishing the bimonthly *JAACP*, the Academy sponsors a variety of programs designed to further the psychiatric care of children, adolescents and their families, including a national continuing education program and a public information service. □

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Copies of the special section available upon request. American Academy of Child Psychiatry, 3615 Wisconsin Ave. NW, Washington, D.C. 20016.

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Bereaved Children Speak

by Dorothy M. Vacca

During my seven years as an elementary school counselor, I have encountered many heart-wrenching situations, but none was more poignant than the year in which three students in the elementary school in which I work lost a parent in November of the school year. Two of the youngsters were in third grade and one was in fourth. Two were sisters. We started meeting weekly as soon as they returned to school following the funeral services. A close-knit, emotionally powerful group formed in which the children had a place to deal with their grief while supporting one another through their personally and collectively felt anguish.

The girls talked openly about their sense of loneliness and isolation during the wake, shivah, and time immediately following their parents' death. Through the expression of their acutely felt emotions of shock, anger, rage, and sadness, they provided rich information relative to how the adults in their environment were helpful to them as well as what they experienced as hurtful and insensitive. Their reactions were so valuable that I asked their permission to share them in this article as follows.

"It was the morning after Thanksgiving. Julie & I were watching TV in the living room. Dad said, 'Good-by, I love you,' the way he *always* does when he leaves for work. I said, 'Good-by, I love you, too,' the way I *always* do. Then, there was a thud." Again and again in our counseling sessions, eight- year old Melissa recounted the morning of her youthful, vibrant father's fatal heart attack as he was walking out the door to work. She was grappling with how incomprehensible it was that a daily, predictable routine could have ended in such a tragic way. Her once secure and reliable world was shattered for a time and she was scared. It took her months of repeating her nightmarish experience before it was integrated and accepted.

"Why didn't anyone talk directly to me, tell me what was happening. You'd think I had died, too," exclaimed Melissa's older sister, Julie, as she shared her feelings and thoughts about the events of that fateful day. Her rage, fear, and sadness cut through every sentence. Not only had she lost her father but her mother and relatives were dealing with their own shock and grief and were, for a time, unable to attend to her. When she most needed people close to her to affirm the legitimacy of her feelings and, therefore, her existence, those people were unable to support her.

Eight-year-old Andrea relived the bewildering events of the day her mother died: "The principal appeared at my classroom door and spoke to my teacher for a couple of minutes. They looked at me as they were talking and I knew something terrible had happened. I felt strange, scared. My teacher called me to the door and told me to go to the office with the principal. I saw my cousin standing in the hall and I thought my mother must have died. My mother had been sick for a long time with cancer. The night before I went to visit her in the hospital. My older sister told me she was going to die soon, but when I saw her, she seemed better. I had known for a long time that she was going to die, but I didn't think it would happen just now. I still had some things I wanted to say to her. That morning my cousin came to take me to the hospital to see her one more time, but she died before we got there. I wanted to go home and be alone, but I had to go to my grandmother's house. My parents were divorced and I wasn't sure where I was going to be living, probably with my father."

Be Sensitively Direct

As the children talked together sharing their experiences, thoughts, and emotions, common themes emerged. The children needed verbal acknowledgement of their existence and their pain. Not only had they lost one parent to death, but they had lost their other parent and close relatives to grief. As a result, their vulnerability was intensified. They felt acknowledged when adults expressed their condolences directly to them.

Statements as simple as, "I'm so very sorry that your mother died. I know you will miss her very much," helped console and validate their emotional loss. They became angry when they heard people say to relatives, "Please tell the children how sorry I am." They felt ignored - as if they were not important enough to be spoken to directly.

They wanted to hear positive statements about the deceased parent. "Your father was a good man. I know you'll miss him," or "Your mother was a very loving woman," were eagerly taken in so long as the tone was emotionally authentic, honest, and simply stated. Comments about the pride the deceased parent felt for his daughter or examples of times when the girls pleased their parent were also valued.

Gentleness was greatly appreciated. Direct statements and curiosity questions such as, "Your mom died. How do you feel about it? How did it happen? How old was she?" were too jolting. "I heard your mom died. I'm really sorry. If there is any way in which I can help, let me know," were soothing.

Help To Coach Children

Close and trusted family friends can play a very important role with the children. They were concerned about protocol , especially around the funeral. Having someone explain to them ahead of time what is going to happen and what behavior is expected of them during the wake, funeral, shivah, and time of mourning following the service was tremendously reassuring. Specifically, they needed to be told the words to say to the guests, i.e., "Thank you for coming. It means so much to me." "Yes, I did love my father very much and I will miss him." "Excuse me, please. I need to be alone for awhile."

The children needed attention from many adults at the same time as they needed space and time alone. They wanted to feel they could go off by themselves "to hug my teddy bear" for a while and then come back. They were concerned about social etiquette and being impolite. It helped greatly when adults verbalized to them they understood if they left or didn't respond to a question or continue a conversation. "It is o.k. Don't be afraid of hurting my feelings. I will not think you are rude," helped alleviate the emotional burden they were carrying. One child said, and the others immediately agreed, "When you hear the word 'died,' your ears perk up and you feel you want to be alone."

The children liked hearing stories about their deceased parent. They enjoyed reminiscing with adult family friends of times they shared together and humorous or special events that the adult witnessed between the child and her deceased parent.

Wanting to Talk

The children wanted to talk about their parent, but in private. They appreciated invitations to discuss what happened, but did not want to feel forced to talk. A low-key approach with much tolerance for silences and taking the lead from the children worked best. Giving the children your telephone number with an invitation to call, calling them once a week to ask if they would like to get together, or setting a time when they may visit was reassuring to them. These gestures helped them feel a sense of continuity, that they would not be forgotten, and that caring adults would be there if they needed them. Although they may not have acknowledged their appreciation and may have even appeared indifferent, adults who reached out in this way had a definite positive impact that was not forgotten.

The most frequent description the children gave of their experience was that they felt they were having a bad dream from which they would soon

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awake, but then having to face the overwhelming realization that it was not a dream. Too much quiet was frightening. They liked hearing voices in the background, having the reassurance that people were close by, and also knowing they could be alone if they so chose. Having reminders of the parent such as wearing the parent's sweatshirt, looking at photographs, special gifts the parent had given them, or a favorite item were consoling.

Certain ceremonies and gestures such as having a book donated to the school or public library in memory of the deceased parent and receiving notes and cards from classmates and teachers had a special impact. Having the classroom teacher and other school representatives attend the wake or funeral was unexpected by the children, but very meaningful. It was important to the children to actually see these people during that time. A gift from the class while they were absent helped them feel they had not been forgotten, were cared about, and they still belonged.

When they returned to school, they wanted everything to be as normal as possible. They did not like having to answer questions or being treated with "kid gloves." They did like hearing classmates express simple condolences. Frequently, they experienced the familiar routine of the school day as an escape from the reality of how drastically their home life had changed.

As the school year progressed, certain times were most difficult. These were Mother's Day or Father's Day, the parent's birthday, holidays, the child's birthday, the first month's anniversary. At these times, they would withdraw and again acutely reexperience their loss. Allowing them to talk and acknowledging their feelings were experienced as supportive and helpful.

They felt uneasy when other children or adults were "too sympathetic," and were angry when children asked "dumb" questions, such as, "Did you get a birthday gift from your father?" They did not want to be viewed as different or feel they were anomalies. It may be judicious to brief classmates and friends on what to say and what to avoid. This may also be invaluable to the peers who often feel awkward and at a loss as to what to say and do.

As time went by, they mentioned a number of things that they experienced as soothing and healing. Among them were discussing happy times they had spent with the deceased parent and achievements that they knew would have pleased their parent.

It has now been two years since the death of these girls' parents. Following that first intense year, they no longer wished to meet as a group. However, I have kept in contact with the children. One continues to see me on occasion, another avoids me, and the third has moved on to middle school. Their level of academic and social functioning has returned to normal, but their home lives have changed dramatically and their pain is still not far from the surface.

With special gratitude to Andrea, Julie, and Melissa for allowing me the privilege of entering their worlds.

Selected Resources for School Aged Children

Grollman, Earl A., *Talking About Death: A Dialogue Between Parents and Child*, 1970, Beacon Press.

Krementz, Jill, *How It Feels When a Parent Dies*, 1981, Alfred A. Knopf.

LeShan, Edna, *Learning to Say Goodbye, When a Parent Dies*, 1976, MacMillan.

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NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS

CHILDREN AND ANXIETY*

by Thomas Huberty
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Background—Anxiety is a familiar term and is a common experience for both children and adults at many times in their lives. For children, it is difficult to distinguish anxiety from fear, but generally anxiety is seen to be apprehension about future events that have not yet occurred. Fear, on the other hand, is a response to a situation, such as a child being afraid of an animal. The focus of this discussion is on anxiety, which is a feeling of apprehension without any apparent cause. Anxiety is a normal experience for all of us at one time or another, and becomes a concern when it becomes excessive and/or interferes with one's typical daily routine. Anxiety can be experienced by a person as a long-term feeling or it may occur in a specific setting, such as when taking a test.

Anxiety may occur in response to specific situations such as speaking in front of a group, or be shown in many situations. Children who are referred to as "high-strung" may show some of the signs of anxiety. Some common characteristics of anxiety are oversensitivity to normal events, fear of future outcomes, concentration difficulties, distractibility, impulsiveness, inattention to schoolwork, excessive movement, sleeping problems, rapid breathing, nausea, headaches, stomachaches, unusual fatigue, and, in extreme cases, running away from a situation. Not all of these characteristics will be shown at one time, however, and all may be signs of other problems.

Development—Young children experience anxiety normally as a process of growing up. Infants tend to feel anxiety about falling, loud noises, and having physical needs met. Anxiety in infants is shown in generalized activity that becomes more specific with age. At about 7-9 months of age, babies start to show anxiety of new people. It is at this point that the child can distinguish typical caretakers from strangers and he/she is apprehensive (anxious) about the absence of familiar persons. This form of anxiety is shown by refusing to be held by strangers, clinging to parents, and crying when alone with unfamiliar people. This "stranger anxiety" usually ends by about 12-14 months. At about 18-24 months, children demonstrate a related type of anxiety called "separation anxiety." This anxiety is shown by crying, temper tantrums, and attempting to cling to parents or caretakers. While this form of anxiety appears to be similar to stranger anxiety, it is different from the child's perspective. The anxiety is not a response to what might happen to the child if held by a stranger, but to the possibility that the parents might not return and to what might be the consequences of their not returning. By the time children enter school, these forms of anxiety ordinarily have dissipated and the child is more secure about being with strangers and not concerned about being left by parents.

As children progress in school, they tend to become anxious about being accepted by peers, overall school performance, expectations set by parents, physical appearance, and feelings of competence. They also may hold increased anxiety about the stability of family relationships, death, and the future. Research has shown that girls tend to show more general anxiety than boys and more centered around social acceptance and popularity. The reasons for these findings are not clear, but may be related to the social roles that girls are expected to maintain in our society.

Recognizing the signs of anxiety and knowing when they indicate problems is not an easy task. If you see some signs of anxiety, the following questions should be considered:

- Is the anxiety typical for a child of that age?
- Is the anxiety seen across many situations or is it limited to a specific situation, such as speaking in front of the class?
- Is the anxiety of a long-term nature or has it occurred recently.
- Are there events going on in the child's life that are causing stress and pressure?
- Is the anxiety a sign of a larger problem, such as home and family difficulties?
- Is the anxiety having a great effect on the child's personal, social, and school functioning?

The last question is the most important, because if the child is having difficulty with everyday activities, the problems must be addressed regardless of their cause. By attending to the degree to which anxiety might be interfering with the child's functioning, answers to the other questions will become important in determining the nature, scope, and source of the child's anxiety. Once the entire situation is understood, then plans to work with the anxiety can be developed.

*From **Handouts** (1990), edited by Alex Thomas. A publication of the National Association of School Psychologists*

The Causes of Anxiety—The potential causes of anxiety are many, but the primary characteristic is that the child or adolescent is uncertain about something that has not yet happened. It matters little that the anxiety about a situation may not be realistic or justified. As long as someone feels uncertain whether something in the future might have a direct effect, he/she may become anxious. Anxiety is most likely to be shown when the person feels that something bad will happen and that they have no control over it. It is when people are apprehensive about the future and feel unable to do anything about it that anxiety is most likely to occur.

Nearly any event or circumstance can cause anxiety by creating a situation in which the person cannot predict an outcome and feels unable to make significant changes. Family problems (e.g., pending divorce, competiton with siblings), excessive or unusual discipline practices, inconsistency in how children are handled or treated by adults, high expectations and standards set up by the child or others that are perceived to be unattainable, peer pressure to conform or "fit in," rejection (or, in some cases, acceptance as the child must now meet new expectations) by peers, high needs for achievement, concerns about success or failure, physical appearance, and ability level in a variety of areas are some of the factors that can contribute to the development of anxiety in children. It should be noted that anxiety often is shown in these situation, which is normal. Anxiety becomes problematic when it becomes so intense that the child's personal-social and/or school functioning begins to deteriorate.

Sometimes, there may be more than one factor contributing to the child's anxiety. The author once was asked to consult with school personnel about a 15-year old girl who complained of "test anxiety" in which she "froze" when taking a test. It was determined that she was indeed so afraid of getting a low grade that she could not perform. Moreover, she was concerned about disapproval from her mother if she got a low grade, and that she would have to compete even more with her new stepfather whom her mother had recently married.

What Can I Do As A Parent?—In determining if anxiety is present and is a problem to be addressed, you as a parent should consider the following questions:

- — Are there signs of anxiety that are not typical for my child's age?
- — What are the signs of anxiety and how do they affect my child's personal, social and academic performance?
- — Is the intensity of the anxiety much higher than the situation would indicate it should be?
- — Are there unusual circumstances that might contribute to the anxiety that may change or be changed within the immediate future, such as family problems?
- — Does my child feel that expectations and standards are too high to be met?
- — Is the anxiety only a sign of a more serious problem that the child is experiencing?
- — Is my child's behavior essentially normal, but people around him/her are having difficulty being tolerant of the behavior?

In terms of some ways to deal with anxiety, the following guidelines might be helpful:

- — Provide as much consistency as possible in handling and discipline.
- — Set realistic goals and expectations for yourself and your child that are reasonable and attainable.
- — Try to keep as consistent a schedule as possible in terms of homework, household chores, activities, etc.
- — Listen to your child. Many times, a child will feel anxious about a specific situation and all he/she needs is to talk to someone who will listen and give advice only when asked.
- — Do not assume that the child is just being difficult, as the anxiety may be a sign of a more significant problem.
- — Do not assume that it will "go away," as you may end up not recognizing a potentially serious problem.

RESOURCES:

If the above questions and suggestions do not provide you with the help you need, it may be that the child's anxiety is a sign of a larger problem that must be addressed. In these cases, the school psychologist or counselor may be very helpful in providing you with information about your child as well as helping to obtain counseling or similar services. Your family physician, local mental health centers, ministers, or other professionals may be helpful in understanding the problem and providing you with help.

Children and Reactions to Death

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BACKGROUND

Children must deal with the separation and loss of significant others more often than most adults realize. Divorce, family mobility, hospitalization, and death are all instances in which a child must cope with and try to understand the loss of a loved one. Each situation has the same results; all are accompanied by grief. Jewett (1982) has reported that no matter how trivial a loss, individuals must go through the same process of grief resolution, though the length and intensity will differ. Loss is viewed as a cumulative process in which, without complete resolution of a minor loss, subsequent less significant losses are likely to provoke similar stress.

While exact figures are not known, it is estimated that 5% of the children in the United States (1.5 million) lose one or both parents by age 15 (Kliman, 1979). This chapter will discuss children's reactions to the death of a parent; however, it should be remembered that similar reactions are seen when a close relative or other loved one dies.

DEVELOPMENT

The child's level of cognitive development plays a primary role in the extent to which a child will understand the loss of a parent. Krupnick (1984) reports that the tendency to impose adult models of death resolution on children has led to misunderstandings about children's grieving. Specific manifestations or reactions as well as their duration are different for adults and children. These differences necessitate an understanding of childhood grieving on the part of the school psychologist and others and one should not expect that children will express their emotions as adults do. Children's overt behaviors during the grieving process are often misinterpreted because they often do not reveal their internal distress.

A child's need to ask the same questions about the death over and over is more of a need for reassurance that the story has not changed rather than a need for factual accuracy. Reactions that appear to be unemotional such as telling strangers, "My daddy died" is the child's way of seeking reactions so that they can gauge their own reactions. Emotions may be expressed as angry outbursts or misbehaviors that are often not recognized as grief-related. Children are likely to manifest such grief-related behavior and affect on an intermittent basis for many years after a loss occurs. Such behavior reflects the cognitive and emotional capacity of the child.

Kastenbaum (1967) reported that an understanding of the developmental concept of death in a child is only one factor that must be addressed in understanding the grieving process in children. The second major factor is "ourselves" or the adult's view of death. The adult's own problems in coming to terms with death can have a significant effect upon the child and may complicate rather than facilitate the child's quest for understanding.

Developmental Phases in Understanding Death

While it is generally agreed that prior to the age of 3 or 4 years children are not able to achieve complete mourning, controversy remains over the years between early childhood and adolescence. The controversy centers around the question of whether a healthy resolution can be reached and the similarity between adults' and children's bereavement reactions. Before discussing children's reactions to death based upon chronological age, two points need to be made. First, the specific age references are not rigid but are to be used as rough guides. Second, children may regress to an earlier stage when emotionally threatened.

Given that infants and toddlers seem to lack conceptions of death, they nevertheless seem to explore the state of nonbeing. Maurer (1966) held that the infant experiments with the idea of death in games such as peek-a-boo, in which the baby risks and experiments with being and nonbeing. Another example is the familiar phenomenon of a child sitting in a high chair and throwing objects on the floor for others to retrieve. Gradually the child comes to realize that not all things come back and some may be "all gone." These early experiments with being and nonbeing may be a child's first steps in understanding death. The preschooler believes that self-identity has no limit in time. Periodically, one's condition changes somewhat in the same manner as one might sleep and later be awake. So also, one is "made dead" and later returns to ordinary life.

Children between the ages of 3 and 5 years deny death as a final event; death is seen as reversible. The dead are simply considered "less alive." But children functioning in Piaget's preoperational level of development tend not to recognize the irreversibility of death (Piaget, 1951). During this early stage of development of thought, the child seems to regard death mainly as a separation, a departure. As such, they make statements such as "Daddy will be back soon."

Between the ages of 5 and 9 years a child begins to comprehend the finality of death (Nagy, 1948). A seemingly detached inquiry into death is accompanied by two important assumptions. First, that death is accidental rather than inevitable. A child may report that "If you get run over, then you would be dead" or "He is so old, that is why he is dead." Individuals die under certain circumstances and if those circumstances do not occur then one cannot die. Children at this age do not believe that one must necessarily encounter a death-dealing situation at all. Their second assumption is that they themselves will not die. Death is seen as something that will happen to others.

Children around the age of 4 to 6 years are prone to misinterpret superficial events as being intrinsically

involved in death. For example, children who have known someone who died in a hospital feel a need to stay away from hospitals to avoid death. Such children seek to isolate any events that "mean" or "cause" death (Kaustenbaum, 1967).

Jewett (1984) pointed out that children process information differently from adults. Young children, prior to age 7, use "magical thinking" during the egocentric stage of life. Personal thought, wishes, and actions are believed to be the causes for what happens. Children walking down the street carefully avoiding the cracks out of fear that "step on a crack, you break your mother's back" is an example of magical thinking. Young children who experience a loss will almost always display magical thinking ("If only I would have stayed home, it would not have happened"), and often adults display magical thinking in times of crisis.

Between the ages of 5 and 9 years, children can neither deny or accept death as an authentic aspect of their life. A compromise becomes necessary involving an acknowledgment that death is "real" but only in an external and distant sense (Kaustenbaum,1967). For this age group there is a tendency to interpret death in anthropomorphic terms: death is a person. Only those die whom the death-man carries off. The death-man is usually regarded as a creature of the night.

After the age of 10 years children have generally made the transition in both mental development and emotional security to express an understanding of death as a final and inevitable event that is associated with the cessation of bodily functions. The death-man is no longer feared.

Children need to develop some understanding of what is alive before they can fully understand the concept of death. Researchers disagree somewhat concerning the process by which children learn to distinguish the living from the nonliving, as well as the exact age when this understanding may occur. However, there is evidence to suggest that most children are capable of approximating an adult's view of the living and nonliving by age 10 (Huang & Lee, 1945; Klingberg, 1957; Russell, 1940; Strauss, 1951). As a child reaches adolescence there is a capability of understanding life and death in a logical manner (Anthony, 1940; Piaget, 1930).

Adolescence presents a new set of problems in the children's understanding of death. As the adolescent begins to gain more independence and starts looking forward to the future, there is the realization that all future plans require time, and death may come at any time to prevent these plans from reaching fruition. The adolescent soon realizes that each person grows up only to die.

Developmental Phases of Grief Resolution

Age not only affects children's understanding of death, but also determines how they might react to the loss of a parent. Comprehension of this fact is vital for the school psychologist or other helping professionals working with children. Natural reactions to death need to be understood so that those working with grieving children will be better able to support them during this time. Jewett (1982) identified three phases that children, as well as adults, go through in order to reach some resolution. It must be understood that these three phases are not discrete stages and some overlap may be seen. Anniversaries such as birthdays or special holidays may bring on a temporary regression to a previous phase. Also, the length and intensity of each phase is dictated by the seriousness of the loss and the children's coping capabilities.

During the initial phase of early grief, children's reactions are shock and numbing. The realization that a parent has died results in a mechanical process of completing daily activities; one seems to be simply "going through the motions." A flat affect is observed that may be combined with sudden outbursts of panic. Children will ignore friends and not get involved in activities that were pleasurable prior to the parent's death.

After the shock has subsided, there is typically a reaction of alarm. The alarm results because a child who loses a parent has questions of who is going to care and provide a safe environment. Physiological changes occur, such as an increased heart rate and muscle tension. Insomnia, as well as susceptibility to illness, are also common reactions. Such symptoms are likely to occur on an intermittent basis as the child processes the reality of the situation.

Denial and disbelief are also behaviors that may be exhibited during the initial phase of grief. Children may not accept the loss and may report that the deceased was seen or that his or her voice was heard. This denial allows children to shut out the hurt if it is overwhelming and to deal with the loss when they are feeling less threatened. The denial can be exhibited in many ways. Deprecation, contempt, or other efforts to devalue the lost person are all forms of the denial process. Adults may also see such children as hyperactive and unable to sit and attend for any length of time. Keeping busy is the child's way of avoiding the possibility of having to think about the loss.

Phase two, acute grief, has several characteristic behaviors such as yearning, searching, disorganization, despair, and ultimately reorganization. The death of a parent leaves a child wishing for a different ending. A child's world is filled with make-believe and fairy tales of which the endings are always happy. Children identify with those they read about or see on television and naturally wish for a reunion after a loss. This yearning is a stage of grief that will recur for some time. Resolution is reached gradually as the repeated yearnings are not met and the child understands the reality of the loss and separation. It is the mastering of these feelings about the loss that ultimately leads to resolution.

This phase is often characterized by strong feelings of sadness, anger, guilt, and shame. Adults who allow a child to experience these feelings as natural will be greatly facilitating the grieving process. The supportive adult during this phase must realize that it will take a long time before the child feels better. Once the stage of intense feeling starts, it can take 6–12 weeks for the worst pain to subside, and as much as 2 years before the grief process is completed (Jewett, 1982).

The last phase involves the integration of loss and grief in which the child begins to reorganize daily activities. Acceptance of the loss results in less frequent and less intense crying. Often the child is able to verbalize an awareness of their experience of grief, and a feeling of growth is evident.

PUTTING CHILDREN'S REACTIONS TO DEATH IN PERSPECTIVE

While an understanding of developmental trends and behavioral reactions of a child to the loss of a parent are important to know, there are also several other factors that need to be considered. How to explain the death of a parent to children, the circumstances when children should attend funeral services, and the effect of religious beliefs affect our interventions. Also, the child's age, sex, and prior relationship with the deceased as well as the circumstances of the death need to be considered.

When a child has lost a parent or loved one, there is always the question of how to explain the death. The death of a parent is best imparted by the adult to whom the child feels closest. If one parent dies and the remaining parent is unable to tell the child, then the child should be informed by another adult who is close to the child.

A clear message needs to be given to children that it is not their fault that the parent has died. They need to know that there is nothing that could have been done or can be done to make things different. Adults also need to realize that past experiences help them deal with the loss of a loved one but children often have no such experience. Two important things to tell children who have experienced the loss of a parent through death are first, that the dead person will never return and second, that the dead person's body will be buried in the ground or burned to ashes (Jewett, 1982).

If a parent has died, the emotional reaction of the remaining parent must be a prime consideration. A parent who is struggling with personal bereavement and shock must not deny a child an opportunity to share in the expression of pain. Talking to their children is often painful for bereaved adults and therefore many parents avoid it. Such an approach may be more to protect themselves from further upheaval than to protect their children. But by not talking to their children, these parents deny them the opportunity to confront their grief and reach resolution.

Adults' concern over interacting with their children is often greater than necessary. Adults need to be reassured that in times of great stress there is a shutting down of awareness on an emotional, intellectual, and even a physical level. A defense mechanism works that tends to prevent the individual from becoming overwhelmed in times of stress. A child's initial reaction may be apparently casual acceptance, followed by crying at a later time period. It may be necessary later to repeat the message that there has been a death of a parent.

During such emotionally trying times there is a tendency for adults to rely upon their children for comfort and understanding. Adults should avoid using their children as confidants; when this is not possible they should seek outside help such as a psychologist or counselor for youngsters involved. Parents should also remember that if they inadvertently say something that they later regret, they can always approach their children again and reexplain or clarify what was previously said.

The single most important message to relay to a child who has lost a parent is "You are not alone; I am with you." Touching or holding a child may do more than any words to relay a parent's message. The facts of the loss should be conveyed in as straightforward a manner as possible. Also, it should be remembered that children get their understanding of life primarily through their senses rather than through their intellects. It is helpful to tie the news to a sensory or bodily connection. Relating news back to what the child has heard or seen makes the information more real.

Once a child has been told of a parent's death, a decision must be made concerning the funeral. Having children attend funeral services is very important (Jewett, 1982; Rando, 1984) as they are thus allowed to share their grief with those whom they love. Not allowing children to attend the funerals may add feelings of insecurity and abandonment. However, the final decision on whether to attend should be the child's. Once a child makes the decision, it should be respected..

Prior to the funeral someone should explain to children who are to attend what will take place, who will be there, and how people are likely to react. (Rando, 1984). This information will help them put personal behavior into perspective. The choice of whether to view or to touch the deceased should also be left up to the child. Adults need to keep in mind that funeral rituals, in and of themselves, entail nothing for the child to fear. Children's fears are often the result of adults' reactions during the grieving process.

The beliefs, meanings, and values that individuals hold for life, death, and the life after death are greatly affected by prior religious training (Rando, 1984). Often adults' statements about "heaven" or "God" in relation to the death of a parent are viewed as efforts to protect the adult, not the child. Adults are often tempted to blame God when unsure of what else to say (Vogel, 1975). While it is understandable, it is also wrong and can have serious adverse effects for the child. Statements such as "God took your father to heaven" or "God wanted him" only serve to make God appear an enemy. Such statements may lead to resentment of God. Linking suffering and death with sin, punishment, or reward is likewise inappropriate (Grollman, 1976).

Besides funeral attendance and religious beliefs, the age and emotional stability of the child as well as the sex of the deceased and of the child need to be considered in order to understand a child's reactions to the death of a parent. Early adolescence also appears to be a particularly vulnerable time to lose a parent (Black, 1978). Children who have had parental relationships characterized by ambivalence or dependence tend to experience more difficult reactions to loss (Raphael, 1983). Preadolescent children, unlike adults or adolescents who have a number of close relationships outside the family, invest

love almost exclusively in parental figures (Furman, 1974). Thus, preexisting relationships and the age of the child may be interacting factors in the grieving process.

Inconsistent results have been noted in studies in which the sex of the deceased parent and the child was investigated. Kliman (1979) reported that from about age 3 and older, a more overt yearning takes place when the opposite-sex parent dies. However, unique anxieties may develop when the same-sex parent dies, especially if the child views his or her role as one of replacing the deceased parent. Studies also suggest that girls are more vulnerable than boys to parental bereavement in general and especially during adolescence more affected than boys are by the loss of a father (Birtchell, 1972; Black, 1978). Kaffman and Elizur (1983), on the other hand, found few differences between boys and girls who had lost a father.

When there is a death in the family, chaos and disorganization usually preside rather than an atmosphere of stability and consistency. The major source of support for children is the parents, but during the period after a death they are often unable to provide an environment that is conducive to healing. When a father dies, the mother's capacity to remain assertive while coping with the loss, as well as the availability of a supportive father figure, influence a child's later responses to the loss (Elizur & Kaffman, 1983). How the surviving parent handles the grieving process and the extent of dependency placed on the child also affect future responses of the child (Hilgard, et al., 1960).

A final factor that affects the grieving process in children is the circumstances of the death. Whether one dies as a result of an extended illness or an accident, in the home or in a hospital, influences the bereavement process. Generally, it is easier for a child to deal with an expected death than a sudden death because of time allowed to prepare. Suicide is generally considered the most difficult type of death to accept (Schneidman, 1972). Specific information regarding children and suicide is reported in this volume, which should be consulted for a thorough review of the literature on death by suicide.

Before considering possible interventions, it is important to discuss whether children can even complete the grieving process. There is considerable controversy as to whether children are capable of mourning (Worden, 1982). Krupnick (1984) believes that complete mourning can only occur if a child has some understanding of death, is capable of forming a real attachment, and has a mental representation of the attachment figure. All of these can occur in children as early as 3 years. Bowlby (1980) held that children can resolve the death of a parent if, first, the parent–child relationship has been reasonably secure prior to the death; second, the child is given accurate information about the death as soon as possible and is allowed to ask questions and receives honest answers; third, the child participates in the family grieving process, including attending the funeral if the child desires; and fourth, a trusted adult can aid in comforting the child on a continuing basis.

On the other hand, Wolfenstein (1966) took an opposite position, saying that children cannot mourn until there is a complete identity formation, which occurs at the end of adolescence, when the individual is fully differentiated. A clear definition of mourning seems to be the basis for much of the controversy, which leads to the question of whether mourning is a detachment/identity process or is an interactional process as discussed by Bowlby.

ALTERNATIVE ACTIONS

It is important to establish continuity in the daily routines of children who have lost a parent. Likewise, families should avoid additional stresses immediately after a major loss. Changing to a new school or moving away to a new neighborhood should be postponed. Losing a parent is traumatic enough; compounding this loss with the loss of friends will only further hinder the grieving process.

Individuals may be unsure of exactly where to start in helping children deal with the death of a parent. There really is not a starting place; one should follow the lead of the child by responding to the questions that are asked and the behaviors that are exhibited.

Additional assistance may be necessary for children who do not appear, over time, to be progressing through the expected phases, as discussed earlier, after the loss of a loved one. However, it is crucial to distinguish normal from pathological grief. To overreact may tend to give children a message that there is something wrong with them, thus delaying resolution of grief. On the other hand, a lack of recognition may delay needed professional help. Intensity and duration are two important factors to consider but the limits can be difficult to establish (Krupnick, 1984). Bowlby (1980) established the following warning signals: the presence of persistent anxieties, hopes of reunion, or a desire to die and persistent blame and guilt, as well as patterns of overactivity with aggressive and destructive outbursts, compulsive caregiving and self-reliance, euphoria with depersonalization and identification symptoms, and accident proneness.

There is evidence that childhood bereavement can be a precurser of later emotional difficulties. The experience of prior emotional problems and the existence of a dysfunctional family system are factors that dictate whether more severe pathological developments might occur after the loss of a parent (Elizer & Kaffman, 1983).

Bowlby (1980) reported that the loss of a parent early in life may render a child vulnerable to future depression. Gay and Tonge (1967) suggested that depression associated with early bereavement tends to be reactive rather than endogenous. However, factors such as the quality of the relationship with the caretakers after the loss may be more influential in determining risk of later depression than the actual experience of bereavement (Birtchnell, 1980). In summary, data are inconclusive regarding the long-term consequences of bereavement during childhood and adolescence. Potential problems are indicated but there is a lack of under-

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standing as to what puts a bereaved child at risk (Krupnick, 1984).

Interventions/Strategies

Once it is determined that a child is experiencing pathological grief, parents or other helping professionals need to decide upon appropriate interventions. Grief therapy, as defined by Worden (1982), involves the use of specialized techniques to resolve the conflicts of separation that preclude the completion of the mourning process.

One approach is bibliotherapy, in which books are used as an avenue to help explain death in an understandable way. Using bibliotherapy can be helpful; however, several cautions need to be noted. First, before giving them to the children, adult caregivers should read the books to be used for the therapy. This assures that the content is consistent with their own approach to death. It also makes it possible to better respond to the children's questions. Second, consideration should be given to the children's age and development so that they can be given books of an appropriate level. Third, the content of the books should coincide with the loss the children have experienced. Fourth, after reading the books, the children should have an opportunity to discuss them with adults. This allows for questions to be answered and misconceptions corrected (Heath, 1986).

Behavioral techniques such as relaxation, systematic desensitization, cognitive rehearsal, and contingency contracting may all be useful in resolving conflicts. Psychodrama techniques of role playing with pictures of the deceased to facilitate the goals of therapy as well as Gestalt techniques such as the "empty chair" can also be helpful.

Melges and DeMaso (1980) discussed using present-time guided imagery for reliving, revising, and revisiting scenes once shared with the deceased. This technique stresses the ability to address the deceased in the first person and in the present time context.

Rofes (1985) discussed approaches such as writing a paper about the earliest experiences with death, drawing pictures of how death is imagined to look, writing poems about the deceased, or writing down what it is like after death. All of these could be done on an individual or group basis.

Finally, it should be noted that while many techniques are not age-specific, others need to be geared directly to the children's age or cognitive capabilities. To implement techniques that are beyond the children's capabilities will only tend to further confuse them and hinder grief resolution.

SUMMARY

Children who experience the death of a parent or loved one often need a support system beyond the extended family. School psychologists and other helping professionals are in a unique position to assist children in grief resolution. Understanding age-related behaviors and children's cognitive understanding of death are both crucial in working with children who have lost a parent. Children will go through certain phases of grief that lead to resolution, and factors such as age, sex, and prior relationships with the deceased, as well as circumstances of the death will all affect bereavement. Additional factors such as how the death is explained to the bereaved children and who remains close to them as a source of emotional support also affect the grieving process.

While most children will proceed through the grieving process without major difficulties, some may need specific help to facilitate grief resolution. There does not appear to be any single intervention that is "most appropriate." Several techniques are useful and can be selected with an eye to the child's age, interests, and cognitive capabilities. The single most important message to relay to a child is that support is available and that as adults we are willing to follow the lead of the child during this critical time.

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Berlinsky, E., & Biller, H. (1982). *Parental death and psychological development.* Toronto: Heath.
A review of over 200 studies to determine immediate or long-term effects on an individual who experiences parental loss during childhood. Information is presented in a research fashion. Topics discussed include emotional disturbance, cognitive effects on the child, family and situational variables, and characteristics of the child such as age and sex at time of parent's death.

Jewett, C. (1982). *Helping children cope with separation and loss.* Harvard, MA: Harvard Common Press.
Discusses how to tell a child of a loss and likely reactions to separation and loss. Information not only on death but also divorce and the similarity of children's reactions to various losses. Practical intervention approaches are presented that facilitate the grieving process.

Osterweis, M., Solomon, F., & Green, M. (Eds.). (1984). *Bereavement: Reactions, consequences, and care.* Washington, DC: National Academy Press.
Presents information primarily on reactions to the death of a closely related family member. Areas discussed include health consequences of bereavement, adult and children's reactions to bereavement, and reactions to different types of losses, as well as interventions to assist in bereavement.

Rando T. (1984). *Grief, dying and death: Clinical interventions for caregivers.* Champaign, IL: Research Press.
Discusses the issue of bereavement, why it is necessary, and how to work with families and individuals. Issues of terminal illness care are presented. Contains a good chapter on funeral practices from a psychological and sociological perspective. Several chapters have exercises at the end that are helpful in exploring personal reactions to grief and death.

Worden, J. (1982). *Grief counseling and grief therapy: A handbook for the mental health practitioner.* New York: Springer.
Describes the mechanisms of grief and procedures to facilitate the process of normal grieving. Also explains how unresolved grief can lead to more serious problems. Distinction is made between grief counseling, which is used during normal grieving, and grief therapy, which is used to work through unresolved grief.

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Information on both death and dying is presented by several professionals. Authors include a rabbi, minister, priest, sociologist, anthropologist, school psychologist, and others. Each discusses death on the basis of his or her background and perspective.

Grollman, E. (1976). *Talking about death: A dialogue between parent and child.* Boston: Beacon.
The narrator explains death to a child whose grandfather has died. This explanation is accompanied by a Parent's Guide, which suggests various ways to use the book. Also listed are agencies that may be of assistance plus further readings on the topic of death.

Kopp, R. (1983). *Where has grandpa gone?* Grand Rapids, MI: Zonderman.
Discusses different aspects of death and grief including the function of funerals. Ideas are presented on helping the child to grieve and reach appropriate grief resolution. Includes a special "read aloud" section for adults to read to children to help explain the meaning of death and ways to cope with grief and loss.

LaTour, K. (1983). *For those who live: Helping children cope with the death of a brother or sister.* Dallas, TX: Kathy LaTour.
Designed to help with the readjustment by the family after the death of a child or sibling. Examines how surviving children react to the death of a sibling. Discusses problems that both parents and children are likely to encounter during the grieving process.

Manning, D. (1984). *Don't take my grief away: What to do when you lose a loved one.* New York: Harper & Row.
Written more from the perspective of the bereavement of a spouse when losing a husband or wife. Stresses the natural process of grieving from the initial shock to recovery. Assists in understanding what happens when someone dies, dealing in a realistic yet healing way with the necessity of accepting the loss and facing the feelings of loss, separation, and even guilt that we experience.

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Hazen, B. (1985). *Why did grandpa die? A book about death.* New York: Western.
A sensitive story that shows children the comfort of sharing feelings and how lasting memories can help wash away the sadness of a death. The introduction presents some "do's and don'ts" about talking with children about death.

Krementz, J. (1981). *How it feels when a parent dies.* New York: Knopf.
Eighteen children of various ages and ethnicity write about their thoughts and feelings when a parent has died. Helps children realize that many of their feelings are normal and shared by others in similar situations.

Mellonie, B., & Ingpen, R. (1983). *Lifetimes: The beautiful way to explain death to children.* New York: Bantam Books.
Beautifully written and illustrated. Explains life and death in a sensitive and caring way. It is a book about beginnings and endings, and about living in between. Uses plants, animals, and people to explain that dying is as much a part of living as being born.

Nystrom, C. (1981). *What happens when we die?* Chicago, IL: Moody.
Explains death from a Christian or religious perspective. Talks about God's role in life and death and heaven as an afterlife. Scripture citations are listed throughout the book for further reference on specific aspects of death.

Stiles, N. (1984). *I'll miss you, Mr. Hooper.* New York: Random House/Children's Television Workshop.
Discusses Big Bird's efforts to understand the death of Mr. Hooper. Shows how Big Bird's memories of Mr. Hooper help him to say good-by. Big Bird's confusion and questions are typical of what many children go through when they have lost a loved one.

ASSESSMENT ISSUES IN CRISIS INTERVENTION

The events precipitating a crisis are outside the control of the school psychologist. Once an event has occurred, however, the psychologist is able, if he or she chooses, to assess crisis events and children experiencing them. Such information is not simply to satisfy the psychologist's curiosity but serves as a data base for both immediate and long-term services to a child or family. Hafen and Peterson (1982) have stressed the importance of assessment during the early stages of a crisis. Their recommendations are useful ones that can be considered in their entirety.

"Look at the situation carefully; assess what the person is telling you as it compares to the situation as you see it. Remember, the person's perception is what triggers crisis. You may think that a man is reacting beyond rationality after some neighborhood children pluck the heads off his roses; what you may not see immediately is that the man learned that morning of his wife's terminal cancer. Assess a person's general alertness and the ability to communicate by asking questions that force a response. As you talk, try to identify the cause of the crisis by asking open ended questions that call for answers: 'What has happened to make you so upset?' 'Why are you away from home?' 'Have you recently lost someone?' 'Is there a reason you need help right now.' Watch the person's posture, body movements, eye movement and mannerisms. Note whether the person is disheveled, intoxicated, distracted, forgetful, abnormally depressed or euphoric, or worried." (p.11)

While some writers may be uncomfortable with the questions proposed by the authors, Hafen and Peterson recommend strategies consistent with proposals of other writers on crisis management. Assessment during crisis can begin immediately and continues until the professional acquires adequate information to make a decision; secondly, information is solicited that allows the person to achieve an emotional and intellectual grasp of circumstances affecting him or her.

Symptoms and signs of crisis may vary broadly across individuals. Personality and temperament considerations may determine how a person displays discomfort or apparent stress. With children, it may be even more difficult to separate situations of normal discomfort, such as injury or mild emotional upset, from more severe circumstances denoting crisis. There are several symptoms that have been proposed as signals of distress and crisis. These signs and symptoms can be broken into the following categories:

Physical signs and symptoms
- change in appetite
- headaches (usually chronic)
- abdominal pain
- rapid breathing
- rapid heartbeat
- extreme muscle tension
- nausea and diarrhea
- weight gain
- insomnia
- ulcers
- digestive upsets
- high blood pressure.

Emotional signs
- nervousness
- tension
- fatigue
- hostility
- anger
- depression
- ambivalence
- inability to make decisions
- panic
- crying spells or constant outbursts of temper
- irritability
- guilt
- paranoia.

Behavioral signs
- inability to concentrate
- preoccupation with the past
- slips of the tongue
- denial
- delusions or hallucinations
- changes in habits
- demanding, clinging behavior
- withdrawal from regular activities
- excessive drinking
- drug use
- criminal or delinquent behavior
- sudden carelessness in dress in a normally well dressed person
- alcoholism

REACTIONS TO CRISES: DEVELOPMENTAL DIFFERENCES

Scott Poland

CHILDHOOD REACTIONS TO DISASTER

- Fear of future disasters
- Loss of interest in school
- Regressive behaviors
- Sleep disturbances and night terrors

PRESCHOOL REACTIONS

- Thumb sucking
- Bed wetting
- Clinging to parents
- Fear of the dark and animals
- Sleep disturbances
- Speech problems
- Loss of appetite
- Toileting regression

REACTIONS: AGES 5-11

- Irritability
- Whining and clinging behavior
- Aggressive behavior
- More competition with siblings
- Night terrors; nightmares
- School avoidance
- Withdrawal from peers
- Concentration problems

REACTIONS OF ADOLESCENTS (AGES 11-14)

- Sleep disturbance
- Appetite disturbance
- Rebellion at home
- School problems
- Somatic complaints
- Decreased peer socialization

REACTIONS: AGES 14-18

- Somatic complaints
- Appetite/sleep problems
- Agitation or decreased energy level
- Less interest in opposite sex
- Irresponsible or delinquent problems
- Concentration problems

NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS

Children and War—Responding to Operation Desert Storm*

TEACHER HANDOUT

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BACKGROUND

Students in the U.S. today have never experienced war as a reality. Although the United States has engaged in some brief military actions, never have our students experienced anything like the events that began with Iraq's invasion of Kuwait and the initiation of Operation Desert Storm.

Also unique to the experience of students of the nineties is the impact of the media on their thinking and feeling. They have been exposed to violence—both real and fictional—in unprecedented amounts. Real violence is replayed on television almost as soon as it occurs. Sesame Street can be interrupted by a report of a sniper in an elementary school and news shows bring conflicts between other countries into American homes.

Today's students also live in the world of Star Wars and Super Heroes. Luke Skywalker may be quickly relegated to the realm of fiction by adults, but for students this is not so easy. Youngsters have difficulty separating reality and fantasy. Students who believe in Santa Claus can as easily believe in Darth Vader and Freddie Kruger. These same students may have difficulty separating the realities of Desert Storm from fantasy of the media.

Almost every American student is likely to have some personal contact with Desert Storm. If a family member is not involved, a friend or a classmate's father or sister may be. All students need the support of caring adults to help them deal with this crisis.

EMOTIONAL RESPONSES

Emotional responses vary in nature and severity from student to student. Students' reactions are determined by their previous experiences, their temperament and personality, and the immediacy of the crisis to their own lives. Nonetheless, some communalities exist in how students (and adults) feel when their lives are impacted by war.

- **Fear:** Fear may be the predominant reaction of many students—fear for the safety of relatives and friends in the military or fear for their own safety. Students' picture of war may include a bomb dropped on their home or school. Their worries may seem unreasonable, but to them, they are quite real. Students may hear many rumors at school and let their imaginations run wild. They may think the worst, however, unrealistic it may be.

The threat of terrorism may be a reason for students to fear for their personal safety, although statistically the chance of any one student being a victim of terrorism is very remote. Nonetheless, terrorism is one more item students may add to their list of worries.

- **Loss of control:** Military actions are something over which students, and most adults, have no control. Feelings of loss of control can be overwhelming. Students may grasp at any control which they can have.
- **Anger:** Anger is not an unusual reaction. Unfortunately, anger is often expressed to those with whom students are most secure. Students may be angry at parents who are in the military to the extent that they do not want to write letters. Knowing that those who are involved in the military are volunteers only helps to justify anger. Patriotism and duty are abstract concepts, especially for younger students who are experiencing the reality of separation from a loved one.
- **Loss of stability:** War interrupts the natural order of things. Stability is gone, and this is very threatening. It can destroy trust and upset equilibrium. After all, if this war can happen, then most anything else might also happen.
- **Isolation:** Students who have a family member involved in Desert Storm but do not live on or near a military installation may experience feelings of isolation. If a student's parents are reserve members called to active duty, he or she may be the only one in the school or class who is directly impacted by the crisis. That student may feel jealous of other students and their undisturbed families and may strike out at signs of normalcy around them.

Another group of students who may feel isolated are dependents of military families who have accompanied a remaining parent back to a hometown or who are staying with relatives while both parents are gone. Not only do these students experience separation from parents, but they also experience the loss of friends, teachers, and surroundings with which they were familiar.

* *The information contained in this handout, though intended to be helpful, does not indicate official sanction or endoresement on the part of the COMMUNIQUE or the National Association of School Psychologists.*

WHAT CAN I DO AS A TEACHER?

- When in doubt about what to do, always be honest with students. There is never the absolutely right thing to say or do. When in doubt, be honest.
- Help students put their fears in perspective.
- Acknowledge the sanctity of each human life while letting students know that the chance of any one individual returning from the Middle East is very high. Death rates in U.S. conflicts have steadily dropped from the time of the Revolutionary War to a low of 0.5% in the Vietnam War. With increases in technology and medical advances, military statisticians suggest a potential loss ratio of 0.3% from battle and 0.1% from other causes in the Middle East.
- Help students to feel personally safe. One of these techniques may help:
  - Using proportions from a map, make a human map. Have some students stand where Iraq, Saudi Arabia, and other Middle East countries are, let others represent European countries, and have some represent the United States. Discuss the distances and how long they take to travel. Even high school students may profit from an activity such as this.
  - Discuss what is realistic modern technology versus science fiction. Help students to understand that the longest range missile that Iraq has can barely reach Israel. Discuss how far Iraqi war planes can fly without refueling (about 1000 miles) and the impossibility of refueling anywhere between Iraq and the United States. Let students share their fears, such as Iraq's converting a plane to carry enough fuel to get to the United States, and put them in perspective as to what is realistic.
  - Help students understand that precautions are being taken to prevent terrorism (e.g. bomb sniffing dogs, passport checks, increased airport security) which might actually make them safer now than they usually are.
  - Deal with fears that Desert Storm may be the beginning of the end of the world as some have predicted based on Revelations or other religious teachings, or that bombs will reach the local community, which may originate from playground rumors.
- Allow students to express feelings. For a class that has numerous students directly involved, a special time might be set aside regularly to discuss feelings and issues. For a class with less direct involvement, specific students might need extra time to talk with you or with the school psychologist or guidance counselor. You might also put families within your school who are directly involved in contact with each other.
- Consider initiating some values clarification activities. Students may need help identifying what they individually believe about war and the role the United States has chosen in this conflict. Questions such as "Could my parent shoot someone and how do I feel about that?" and "How can anyone shoot an Iraqi soldier who is only 12-13—no older than I?" are the types of issues which may need discussion.
- Help students to feel a sense of control by taking some action.
  - Send letters or cookies to those in the military.
  - Initiate a flag flying project where students develop community participation in flying flags until the crisis is resolved.
  - Put together a volunteer babysitting network through which older students sit for families where parents are away.
  - Ask students to think about the men and women in the Middle East prior to the Pledge of Allegiance or involve them in an additional patriotic activity.
- Involve students in planning how to cope. Control and ownership are fostered when students help to plan strategies for dealing with a situation. Students often have practical and creative ideas for coping.
- Be careful not to stereotype or demean the Iraqi people. Children can easily generalize negative statements and develop prejudice.
- Pay special attention to students who may feel isolated. If only one student in a class has a parent who is involved, others can make that student feel special for awhile by attending to their feelings and needs. If a student has relocated because of separation from parent(s), set up a network of others to get the new student involved.
- Identify support services for students and families needing assistance beyond what can be provided in school. Try contacting mental health agencies or local churches and synagogues.
- Be sensitive to financial strains which war might exacerbate. If a civilian parent is placed on active duty, his/her salary may drop. If many military personnel are deployed from an area, support jobs such as waitresses or cashiers may be at risk due to decreased business.

School's Response to Suicide, Death, and Loss

by Peter L. Sheras

There is a certain unnatural feeling when a child or adolescent dies. Something tells us that the world is not in order, that there has been a terrible mistake made, that nothing can be taken for granted any more. We struggle to make sense of the event, to restore our faith in the order of the universe. Everyone is shaken whether they admit it or not. In the school setting we play our part in making sense of the event and in conveying by example, overtly or covertly, what is to be done and what is to be felt. A death of someone we know is disorienting enough, and a self-inflicted death seems almost beyond our understanding.

It is difficult to write about preparing for the unthinkable or that which is so difficult to comprehend. It is almost as though we fear that by preparing for it we might play some part in causing it to happen. Unfortunately, as many of us know, suicide among middle school, high school and even elementary school students is on the rise in this country. More than 6,000 adolescents die by their own hand in the United States according to current projections. Adolescent death and suicide will touch us in our lives and in our work in the near future if it has not already. How is it possible to prepare for this eventuality?

There are many considerations to be pondered. First, we must prepare to deal with the immediate aftermath of the suicide of a student or students. We must look at how it affects the students, the faculty, the family, and the school. We must come to understand that the event does not end with the death but continues to have impact for years. Suicide postvention should be considered in the short and long term. We can view every such tragedy as a prevention opportunity. We can help to create conditions which might make future suicides less likely. A part of this latter strategy is to create crisis response teams in the schools and to raise the level of awareness of all school personnel to help identify those at risk for self-destructive behavior in advance.

Responding to an adolescent suicide is a complex task. We are usually confronted on the first day with a lack of information and a rapidly changing picture from moment to moment. There are also the intense emotions of those involved to be considered. This combination of factors has potential for confusion escalating almost toward chaos in the school.

There are a number of important steps to be taken when a suicide has occurred. Many of these steps are applicable to a variety of school crises related to accidents, disasters or other deaths (such as those of faculty, parents, or important community figures). It is most useful to have anticipated these events by constructing a crisis action plan and performing some training of faculty and staff beforehand. The Phi Delta Kappa Task Force on Adolescent Suicide* suggests a number of activities to be considered in setting up a meaningful plan. These include:

- Deciding who will be in charge during the crisis.
- Holding an inservice for secretaries and staff yearly regarding suicide and how to respond to students, staff, parents, and the media during crises.
- Holding periodic inservice meetings in each school in the system to review behaviors associated with suicide, national and local trends and the availability of local support resources.
- Establishing a telephone communication network or "phone trees" so information can be disseminated easily.
- Planning to meet the space needs in the building or nearby to accommodate crisis meetings and activities.
- Establishing a police liaison.
- Establishing a working relationship with community health, mental health, and resource agencies.
- Practicing the crisis plan by holding a "crisis alert" session with staff role-playing students.

In addition to advance preparation, a suicide crisis action plan must also be constructed. This plan needs to include a number of important steps. During a disorganizing experience such as a crisis, it is essential that some order be asserted. This is best done through the execution of a plan to deal with the situation as it evolves. The Phi Delta Kappa Task Force on Adolescent Suicide+ recommends at least ten steps in an effective plan. These steps range from verification of the death and informing the students in an appropriate fashion to arranging for counseling and helping to prepare for the funeral.

It is essential that any crisis plan also provide for some follow-up with faculty and staff as well as with students. All affected parties will feel the grief and pain of the crisis for a long time. The entire system will be influenced for at least a year and, perhaps, longer. There needs to be a planned approach for how to deal with feelings arising at times throughout the time until the class whose member has died has graduated. It is, for example, necessary to acknowledge the grief

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of those who knew the adolescent without condoning suicide as a rational or acceptable means of coping with life's stresses.

During the period following a suicide there is also an opportunity to work to prevent future incidents. Suicide may occur for a number of reasons. To the extent that such behaviors are a response to stress, programs to reduce pressure and stress may be instituted. If suicide is the result of other emotional factors, training of staff to identify students at risk can be very useful. Often, we must utilize the fact that there is heightened awareness of the need for prevention at this time and act while there is motivation by those in the school system to do so.

Establishing School Crisis Teams and Networks

As a result of the increase in adolescent suicides and suicide attempts in schools and concerns about other mental health issues in the schools, more and more schools and school systems have established crisis teams and networks. The structure and function of such groups differs from system to system. There are some common elements which appear across systems which are important. Some school systems have more resources than others to establish and implement such networks and there are clear differences based upon urban and rural and geographical distinctions.

Most broadly, crisis response groups in the schools can take three forms:

- Crisis teams at the school building level.
- System-wide central office crisis networks.
- Community support groups.

The building level crisis team is often headed by a ranking administrator in the school, usually the Principal or someone selected by the Principal (e.g. an assistant or a school psychologist or counselor) and can be comprised of counselors, school psychologists, teachers, office staff, school nurse, and school social worker. This group is charged with the development of a building level plan to deal with a crisis. The tasks also include developing a training and inservice program for that school's faculty and staff, researching available local resources to support the school during a crisis, developing a logistical plan of how to utilize school space during a crisis and how to assess the need for additional resources, and debriefing after the crisis has occurred. In some schools there is also a desire to have this crisis team meet regularly to identify students who might be at risk for suicide or severe acting out behaviors. System-wide central office crisis networks are established to coordinate the activities of the building level school crisis teams. This group is often comprised of a central office staff member and representatives of the building level teams. This network can be charged to gather materials in a central library for distribution to schools when needed, to make policy regrading the assignment of resources throughout the system during a crisis, to establish links to community support agencies such as mental health centers, and to evaluate the effectiveness of crisis plans and to plan follow- up.

Community support groups can be established to provide help to the schools in times when their resources are overwhelmed or when expertise is needed which is not available in the schools. This group may be made up of police, media, mental health, legal and clergy representatives to name a few. They may meet periodically with teams or networks for the purpose of planning or helping to respond in a crisis.

There is a growing need for the establishment of crisis groups in and for the schools. It is often the School Psychologist who plays an instrumental role in documenting the need for such groups and serving to organize and lead them. It is essential that School Psychologists are aware of how such teams can be established and what resources are available to them. With this sort of structure in place we can begin to respond more completely to crises as they happen and work to prevent them from recurring.

+Phi Delta Kappa Task Force on Adolescent Suicide, *Responding to Adolescent Suicide*, Bloomington, Ind., Phi Delta Kappa Educational Foundation, 1988.

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What To Say When Someone Dies

by Ann Mueller

I began thinking about writing an article like this as I considered the things that people said to me after the deaths of my parents. My mother died 2-1/2 months after my father's death. Between the two different occasions, I believe that my experience qualifies me as an expert on this topic, or at least as an expert on remembering how I felt as I talked with my friends and acquaintances.

I found that people tended to make four different kinds of comments to me after learning about the deaths of my parents. I have grouped the people who spoke to me as follows:

Group 1. People in this group tended to make statements like "I was sorry to hear about your mother," sometimes adding, "Just remember that we're here," or "Please let me know if there's anything I can do," or "I don't know what it's like to lose a parent." I liked the people in Group 1.

Group 2. People in this group said things like, "I was sorry to hear about your mother. My mother died 10 years ago, and I still miss her." It was easy for me to identify with the people in this group, and I tended to have the longest discussions about my loss with people in this group.

Group 3. People in this group were trolling for information. They said things like, "Ann, did your father die?" When I told them that he had, the response was "Oh," or sometimes, "Oh, I wasn't sure what the situation was." There was apparently no understanding that it might be appropriate to extend condolences or acknowledge that there was a loss. I resisted the impulse to scream at these people.

Group 4. People in this group spent their time telling me about their own parents' health. For some, this had followed an initial expression of sympathy, and for some it followed some information gathering. However, the main agenda was letting me know about their own family situations. At this point in my life I really was not the least bit interested in hearing about anyone's mother, and in fact I resented everyone close to my age who still had a mother.

Group 5. People in this group did not make any comments to me about either of my parents.

After thinking about all of the comments that people made to me after both parents' deaths, I submit the following suggestions to anyone who has a friend or acquaintance who has had a death in the family.

Hints

Say something. Not knowing what to say, yet somehow stumbling your way through is far better than saying nothing about the death at all. When nothing is said, the message you are communicating is "You're in this alone."

Don't wait for your friend to bring up the topic. People who are dealing with a loss need a chance to talk about their feelings. However, they won't necessarily initiate the topic on their own unless they are sure that you are ready and able to listen.

Acknowledge the loss. I found that I was touched by statements made by people in the first two groups. What these statements had in common was that they acknowledged that there is a loss. "I'm sorry" is really all you need to say. You may certainly choose to tell your friend more if you want, but make sure that those two words are communicated in some way.

An offer of support will be appreciated. Even if the grieving person does not come over and mope in your living room, a reminder that you are there if needed will be remembered and appreciated.

It's okay to use the words "death" and "die." My preference is to avoid terms like "passed away," but I will admit that this is my preference and is not necessarily everyone's. If others' experiences are similar to mine, the memories of the people we knew are still very real, but the loss is also very real. Using euphemisms like "passed away" somehow denies the pain. I believe that the grieving person will appreciate hearing that you understand that this experience hurts.

Avoid telling a grieving person that it is for the best. This kind of loss hurts a lot, and it will not be helpful to minimize the loss by putting the best face on it. Even a death that follows some pain, distress, and confusion is still a loss for the survivors. You may see that kind of death as an end to the pain, and it might comfort you to say that it is for the best. However, when my parents died, I did not like hearing that it was for the best, and I suspect that other people going through a grieving process would not appreciate this opinion any more than I did.

Share your own loss. If you have lost someone close to you, sharing that experience is appropriate. I found that some of the best help came from other people whose parents had died. We had some long discussions about how it feels

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to go back home and sort through things. However, do this only if your loss is similar. Telling someone who is dealing with the death of a sister or brother about the death of your brother-in-law's aunt will not be helpful.

Avoid discussing your own living relatives. After my mother died, I was not the least bit interested in hearing about the health of my friends' parents. In fact, I resented them for still having parents. Do not burden the grieving person with news about your mother's ulcer, the way your father still drives a car every day, or complain about how your parents are getting so old. Someone who has just lost a parent will not appreciate this.

Recognize that your friend will be experiencing lots of different feelings. Initially, nothing seems real. Immediately after a loss, a person recognizes the reality that someone has died, yet everything that happens seems unreal. It feels like playing a part in a play. For me, nothing that happened at the funeral home seemed real. It is now two months after my mother's death, and now I sometimes feel guilty for still being alive. At other times, I'm angry with my mother for abandoning me, and then again guilty about harboring this feeling. The grieving person will probably reach a point where the strongest feeling is sadness and depression. The loss is there and it is irreversible. I believe that other people around will be in the best position to help if they have some notion of what to expect.

Let your friend know that his/her feelings are okay, and you are ready to listen. Your friend might be embarrassed about the feelings. It will help your friend to know that the feelings are okay.

If you have a friend who has recently lost someone close, you have an opportunity to make a difference in this person's life. Show your friend that you care and are ready to offer support.

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CHILDREN IN CRISIS:
STRESS AND COPING

Children experiencing difficulty in adjusting to the demand in their lives may fail to adequately cope at any given point. As we discussed earlier, younger children may be inadequately prepared to deal with events occurring around them. Chandler (1982) reviewed some major sources of childhood stress which can lead to a crisis if coping skills are inadequate. Common stressful events include peer relationships, school, death of a loved one, divorce of parents, or hospitalization. Literature on each of these stressors has been developing. Millman, Schaefer, and Cohen (1980) and Stein and Davis (1982) are two examples of manuals depicting effective interventions with school-based problems experienced by adolescents.

Chandler (1982) writes that childrens' responses to stress depend on their personality, circumstances surrounding the crisis, and what has worked in similar situations in the past. Two dimensions of personality that can be used to describe behavioral responses are an active-passive dimension and an introverted-extroverted dimension.

Patterns of response to stress may be broken up into four areas: (1) The dependent response can be adopted by children who are often passive and immature. When placed in a stressful situation, they may become immature in their speech and behavior and act silly. They can be characterized as lacking independence in most areas of functioning; (2) The impulsive response is adopted by a child who is readily excitable and restless. Such a child may appear inattentive and distracted in school; (3) The passive-aggressive response is used by children who are often characterized as underachievers and indifferent to their grades. They may appear obstinant and uncooperative and tend to procrastinate; (4) The repressed response is adopted by children who are typically quiet and reserved. They may fail to initiate conversation and appear to be daydreaming.

The complexity of a child's personality as it interacts with stressful events indicates that the school psychologist will be most effective with a child in crisis when that psychologist is familiar with the child's past cycle of coping. Failure to understand common patterns in a child's behavior can lead the psychologist to misread or misunderstand the functioning of the child.

Facing Crises: The Professional's Response

In considering the problems faced by children or adolescents, the professional practitioner begins by reviewing knowledge about the development of children's social, emotional, physical, and cognitive domains. A sound understanding of a child's growth and development enables the professional to understand when a child is functioning at less than optimal levels. While it is easy to name specific problems that come to the attention of psychologists (e.g. sexual abuse, runaways, suicide), it is much more difficult to have a grasp of critical dimensions by which the psychologist can understand and plan for the child's ongoing growth and development.

Aguilera and Messick (1974) propose helping individuals to gain an intellectual understanding of the crisis facing them. For the child, however, school psychologists may be less concerned with intellectual understanding than in eliminating any immediate stressors that can interfere with general functioning. The authors also recommend helping the individual express feelings about stressful circumstances that lead to the crisis. As we shall see, many authors more familiar with services to children make similar recommendations.

Aguilera and Messick continue by recommending exploration of the coping mechanisms and encouraging supportive relationships. Such recommendations are consistent with what we know is useful in serving children.

Of related interest are the recommendations of Hipple and Hipple (1983), who have developed a guide for mental health professionals dealing with hospitalization of clients. Hospitalization in and of

itself is a stressful event and can precipitate a crisis response. According to these authors, a crisis occurs when a usual coping style is no longer adequate in meeting the demands that an individual must face. For children, as we have documented, coping styles are either nonexistent or are tentative at best. Two major categories of crisis can be conceived: (1) accidental--death, unexpected loss, fight with a loved one; (2) situational--crisis during a particular point in life, or a crisis of a developmental stage in the life cycle. The latter category seems most applicable to adults in crisis while the former can apply to just about everyone.

Hipple and Hipple stress the importance of assessment of crisis events. Facts surrounding the crisis situation must be determined to provide a framework for understanding the crisis and allowing the person to vent feelings. Who, what, where, and when questions are the tools by which such information is elicited. Secondly, the psychologist can help the client understand facts surrounding the crisis situation. This would be followed by assistance to the client, and includes understanding feelings and emotions related to the problem circumstances. Consistent with other models is an exploration of possible adjustments or solutions followed by identification and contacting of social supports.

More importantly, Hipple and Hipple (1983) propose action steps by which the psychologist can assist the person under crisis. They recommend breaking the situations down into small segments to be handled. In other words, rather than allowing the child under stress to perceive events in their entirety, the psychologist can help reinterpret stressful events in such a way that situations seem to be less overwhelming. Problems at home, for example, can be described as being problems between the individual actors rather than an intermingled web of events that cannot be untangled.

Secondly, the psychologist can help the child see the crisis situation as a challenge rather than as a threat. Although working from this direction can sometimes seem to be less than helpful, Hipple and Hipple propose that there are certain events that precipitate crisis and can be adequately handled when relabeled as a challenge. For example, problems at home, including unexpected loss of a parent, can be perceived as a motivating force that will enable the child to grow and mature into adulthood.

Next, the psychologist can help the child see his/her reaction to crisis as being very similar to that of other children facing similar circumstances. As is true about adults in crisis, children under stress often feel alone. They believe that they are the only person in the world, or at least the first, to experience a problem. When given the perspective that indeed they are not unique, many people will be comforted rather than irritated that others have faced similar problems and been able to successfully cope.

A final action according to Hipple and Hipple is to redescribe the crisis and set the stage for a plan. Crisis intervention differs from counseling because it does not assume that the clients cannot take an active stance without help and direct intervention. Counseling assumes that clients, whether they are children or adults, can articulate feelings and act rationally. During crisis intervention, however, the individual often cannot do these things. A stage must be set to assist a person to gradually assume responsibility for actions and thoughts.

In reviewing the initial proposals for crisis intervention, the reader may have noticed the similarity of such recommendations to similar proposals for managing stress. Cox (1978), for example, has proposed that stress can be managed or alleviated by attention to specific steps: Alterations of demands placed on the person from the physical and psychosocial environment, alteration of the ability to cope, support of existing abilities to cope, alteration of cognitive appraisal of events, alteration of the actual importance of coping, alteration of the behavioral response to stress, and alteration of the physiological response to stress. Each of these adjustments to a person's coping abilities will obviously have an impact on the extent to which the situation is labeled as a crisis. Such alterations similarly have important implications for treatment or intervention with the child. For example, influencing demands of the environment, whether physical or psychosocial, implies manipulation of forces identified as important from an ecological perspective. Altering abilities to cope implies straightforward training of the person to acquire specific skills. Changes in cognitive appraisal can involve counseling or psychotherapy or the use of mood altering drugs. Physiological changes might also involve the use of drugs or the manipulation of functioning through the use of biofeedback strategies.

The use of counseling or psychotherapeutic interventions with persons in crisis has been discussed by Van Ornum and Mordock (1983). The authors provide a guide to crisis counseling that emphasizes understanding of critical stages in child development. Crises reviewed include those brought about by death, divorce, illness, handicaps, child abuse, foster care and behavioral problems. The authors take a psychodynamic perspective on approaching children in crisis. The approach is associated with an empathic understanding of how children think, feel, and perceive crisis events.

Elements of a crisis for a child include differences in coping styles when compared to adults. The child must continually face new challengs when growing up. He or she cannnot rationalize the need to cope and does not know how to reduce demands that are being placed on them. Faculties for problem solving and dealing with rational thoughts are not fully developed. In contrast, adults have a sense of who they are and their purpose in life. A crisis may temporarily shake their purpose but responsibilities can continue to be met because of well established behavioral patterns. The adult can make choices not to meet responsibilities during crisis. For example, minor tasks can be put aside until circumstances are more favorable. The adult can regulate basic needs and develop strategies of dealing with irrational thoughts. Over time, the adult can gradually feel better and do more than just cope on a day to day basis.

Less intensive crisis circumstances also can elicit different adjustments from children and adults. Children often lack the verbal skills and life planning strategies that can help the adult under crisis. The child lacks the ability to communicate fears and remains in crisis by not knowing how to resolve difficulties. Adults, in contrast, can relive the crisis in their minds and create new aspirations. With problems associated with death, they may be better able to grieve than are children and to go beyond that grief to plan for the future.

Van Ornum and Mordock discuss what are called regressive acts, more primitive behavioral patterns when stress is too great. The person may act out rather than talk through a problem. In a crisis, a child may go through a variety of feelings that were experienced but left unresolved in past similar situations. Because their only resources in confronting a current problem may be based on an unresolved past conflict, children cannot be expected to cope very successfully without support. The nature of upsetting events also has an impact on the child. According to these authors, upsets are distressing disturbances that have three elements: (1) Thwarted intentions, an aim or purpose that is not achieved; (2) Unfulfilled expectations, something that is anticipated or something that the child feels is his or her due but does not come about; (3) Undelivered communications, lack of abilityto think about issues and to communicate feelings about these issues.

Hafen and Peterson (1982) propose six general areas of support that service providers can deliver: (1) Intellectual functioning--problem solving skills can be developed or supported; (2) Interpersonal assets--having friends and family available for support; (3) Emotional resources--ability to face problems through coping skills; (4) Hope--reasons for living and overcoming problems; (5) Healthy personality--combination of the first four factors; (6) Self motivation--desire to take care of oneself.

Looking for assistance from persons sharing religicus beliefs is one implication of the fourth source of support, that of hope. Reasons for living and overcoming problems are indeed basic tenets of many established religions. Support from religious groups may be available to provide assistance under other areas of Hafen and Peterson's list.

In a crisis situation, the child can be faced with either predictable or unpredictable events. Predictable events or crises often are related to stages of development. They usually allow time to make flexible and realistic plans to reduce stress and anxiety. For example, adolescents grow into adulthood, single people can plan to be married, and working adults plan for retirement. Unpredictable events are by definition less subject to control. Natural disasters occur, accidents happen, suicide and attempted suicides occur, as well as other unexpected or tragic life experiences. In all predictable and unpredictable crises, the events themselves may be problems that lead to anxiety, confusion, or disorganized problem solving. Old methods of coping may fail or old methods may not change the continuation of a problem event. Anxiety about failure to cope may indeed worsen the overall problem. Solutions may have been tried without success so that tensions

deepen. On the other hand, solutions may finally work and a crisis ends. Finally, an individual can simply give up and allow anxiety and tension to lead to depression.

Hafen and Peterson (1982) recognize the importance of affecting change for people experiencing crisis. Their recommedations are many, but I think easy to understand. First, they state that acting quickly in coming to a person's aid is extremely important. During initial contact, the professional can work to control a person's environment. Events that contribute to crisis circumstances or make situations worse can be eliminated by providing a protective context. When control is established, the assessment of the person can begin. Assessment is defined as gathering information to help make decisions, not necessarily the administration of formal tests.

Once the professional understands what is occurring, necessary adjustments can be made to solve the crisis quickly. With the feedback of the person in crisis, the professional can set limited goals for that person, foster hope and expectations, and assist the person to contact support systems. All elements operate to plan for the future as well as to promote a good self-image and self-reliance.

The two authors provide important information on children in crisis. They recognize, however, that work with a child cannot occur without a parent or guardian's approval unless the child's life is endangered. The authors recommend dealing with issues once the child has some rapport with the professional. Children may not understand the importance of what you are asking and not have the skills to adequately express themselves. By allowing the child time to become comfortable or getting them involved in games or storytelling, you can allow the child to be relieved of the additional pressure from too rigorous questioning.

Giving a child food and allowing comforts in the environment will contribute to letting the child relax. Keeping sessions short is important for this same reason. The authors recommend not lying to the child but helping the child to adjust to events that are painful by using honesty. Getting the cooperation of other adults is critical, especially when those adults are in the child's family. Expressing honest emotions is also seen as important. Protecting the child from negative comments from others that surround them is important during the crisis stage. The authors finally recommend not taking the child's reactions personally because the child, out of fear and anxiety, may say things that are not thought through.

An additional series of recommendations on crisis intervention has been provided by Eddy, Lawson, and Stilson (1983). While the authors focus on substance abuse and suicide, their recommendations have applicability to a wide range of crisis events. Professionals can use emotional ventilation, helping the client so that emotions can be expressed. The service provider can assist by reflecting feelings, identifying and labeling emotions, and not allowing emotional binging to take place because it may interfere with the primary goal of problem solving.

Gathering information under these circumstances involves identifying what is going on, who the principal players are, what is being done, and making a judgement as to immediate needs. By identifying the sequence of events that lead to a crisis, the psychologist can assist in identifying patterns of problem development. By knowing what has happened before and what has helped before, the professional is in a position to make recommendations for the future.

Developing solutions to a crisis event then will proceed. Alternative plans of action can be generated and the child can assist in choosing a single plan. Taking action is important in crisis resolution, and involves the generation of lists of resources for additional help. Most important of all is follow-up. During this stage of support to the child, the school psychologist can deliver additional assistance as well as check on the impact of plans already established.

By definition, crisis intervention is a short-term process that has certain limitations of time and process. All needs may not be met within the time limits, resulting in referrals to support services. Follow-up by the school psychologist is of critical importance in ensuring the delivery of added services. As will be discussed later, management responses to crisis events can be assumed by the school psychologist. Whether or not the psychologist is assigned primary responsibility for ongoing direct services, the professional can tap community resources to deliver services in the plan of intervention. By monitoring the implementation of interventions and assessing the impact of services, the professional guarantees the proper evaluation of service delivery.

TIPS FOR TEACHERS IN DEALING WITH CRISIS

Scott Poland

There have been many varied crisis situations which have impacted the school. There will be occasions when administrators, counselors and psychologists can not provide immediate assistance to all who need it during a crisis. Teachers can provide very valuable assistance. The goal of crisis intervention is to provide immediate assistance to restore normalcy and minimize debilitating lasting effects.

VERIFICATION

Your principal will verify the extent of the crisis and notify you as soon as possible. Please be very cautious about commenting to students until you are notified of the facts. Tell students that it is important to stay calm and that rumors can get out of hand and that you will give them the facts as soon as possible.

OUR CRISIS REACTION

Reaction to a crisis can fall into the categories of panic or defeat. It is normal to have lots of anxiety and to want to flee the scene or to feel that the world is not a very secure place. Unresolved issues based on our life history may surface and add to our emotional state. Waves of emotions may flood our thoughts.

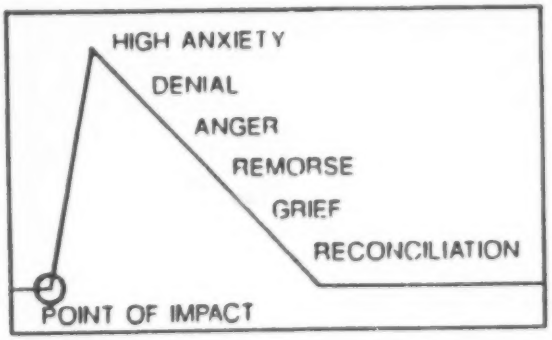
WHAT CAN THE TEACHER DO?

1 After receiving verification from the principal you should openly and honestly acknowledge what has happened. Students need to be told the facts in age appropriate terms. This will help de-escalate the situation.

2 Model expression of your feelings and give the students permission to express their feelings. By giving permission to express feelings, they become validated leading to return to normalcy more quickly.

3 It is important that students understand that they may be flooded with waves of emotion and there is not one correct way to feel. Our emotions range through these stages and we can go back and forth through them.

"VICTIM'S RESPONSE TO EMOTIONAL CRISIS"



Anger and denial are very common feelings. Students may also experience feelings of guilt that are very irrational. This may range from confusion about causality in a young child (i.e. dreams or bad thoughts of mine caused this) to I should have stopped or prevented this crisis (i.e. if I had been there or I should have taken more action). Some students may have valid reasons to feel guilty if they had some knowledge or clues about another person's behavior (these students need to be referred to the counselor).

4 Following the crisis, be alert for those students who are experiencing more extreme reactions in comparison to the norm and refer them to the appropriate counselor.

5 Once students are physically safe they need the opportunity to talk out feelings concerning having their safety and security threatened.

6 We have a tendency to expect all students to react to bad news with feelings of remorse. Give permission for a range of emotions and recognize the student who says today "I don't care or it doesn't bother me" may be crying tomorrow or next week. Students may show their feelings through "acting out" behaviors.

7 Provide opportunites for students who wish to do so to express thoughts through their writing.

8 Be prepared to provide follow-up discussions as needed in the future or as more information about the crisis may last a long time.

DEALING WITH DEATH

A death in the school family (either a student or faculty member) is difficult. Statistics indicate that as many as 1 out of every 750 students die or are killed each year. The life event history of each person will have a great deal to do with their ability to cope with a death in the school family.

1 Tell students about the death in a quiet and direct manner.

2 Avoid religious platitudes and recognize the varying religious beliefs held by students.

3 Give permission for a range of emotions.

4 Do not offer unnecessary details but do answer all questions.

5 Physical contact may comfort some students.

6 Discuss the meaning and effect of the loss and discuss funeral etiquette, and appropriate memorials or remembrances of the deceased.

CHILDREN'S RESPONSE TO CRISIS: A DEVELOPMENTAL PERSPECTIVE

Margaret M. Dawson

The crisis children typically face involve family troubles such as economic reversals or abuse, environmental changes such as moving or attending a new school, sibling difficulties, or losses such as parental death or divorce. Less often, children are exposed to violence or natural disasters such as fires or floods. In most cases, the crises children face are personal emergencies, usually affecting the immediate family only.

In contrast, the war in the Persian Gulf is a crisis that television brings simultaneously into every American living room. Even children without close relatives in the Middle East are affected by this crisis because the television images are vivid and almost unavoidable. Those who have relatives serving in the miliary are at a much greater risk for psychological stress.

These article provides an overview of the reactions children have to crisis situations. Universal reactions as well as specific age level responses will be reviewed. Suggestions for how adults can respond to children are also included.

Much of the material for this paper was drawn from two sources:

Allen, J. and Anderson, E. (1986). Children and crises: A developmental guidance approach. Paper presented at the meeting of the American Association for Counseling and Development, April 1986. (ERIC Document Reproduction Service No. ED 920)

Lystad, M. (ed.). (1986). Innovations in mental health services to disaster victims. Rockville, MD: National Institute of Mental Health (ERIC Document Reproduction Service No. ED 277 920).

Common Responses to Crisis

Children respond to crisis or prolonged stress with feelings of anxiety, confusion and depression. They may display behaviors common to children of a younger age and may have difficulty sleeping or have other night disturbances. A loss of interest in school and difficulty concentrating is common. They may become uncommunicative, frequently responding, "I don't know," when questioned.

Children under stress are often defensive and easily angered. Children respond to a crisis by displaying the same stages Kubler-Ross (1969) has associated with adult responses to loss, including shock or denial, anger, bargaining, depression and hopelessness, and resolution or recovery. Allen and Anderson (1986) have noted, however, that children do not pass smoothly from one stage to the next but, rather, they

"tend to rapidly cycle in or out of the first four levels". The authors also note that the denial stage is often difficult for parents and teachers to deal with because children at this stage resist help or support. The focus, therefore, should be on relationship building and empathy.

Specific Age Level Responses

Preschool (1-5 years)

Typical responses:

Thumbsucking
Bedwetting
Fear of the dark or animals
Clinging to parents
Night terrors
Speech difficulties (stammering)
Appetite loss or increase

At this age, children react to the loss of a previously secure world. They look to family members for comfort and are often strongly affected by the reactions of those around them. A prominent feeling at this age is fear of abandonment.

The adult response at this age should be to encourage the child to express feelings through play, provide reassurance and physical comfort, and give frequent attention. Family routines, especially bedtime routines, should be maintained.

Early Childhood (5-11 years)

Typical responses:

Irritability
Whining
Clinging
Aggressive behavior at home or school
Competition with siblings for parental attention
Night terrors, nightmares, fear of the dark
School avoidance
Loss of interest and poor concentration in school
Withdrawal from peers

Most common with this age group is regressive behavior. In response, adults should be patient and tolerant, relaxing expectations at home and at school (with the understanding that this is a temporary measure). Play and discussion sessions with adults and peers should be made available. Structure should be maintained with chores and responsibilities at home that are not overly demanding.

Pre-adolescent (11-14 years)

Typical responses:

Sleep and appetite disturbance
Rebellion at home
Refusal to do chores
School problems (e.g., fighting, withdrawal, attention-seeking, poor concentration)
Physical problems (e.g., headaches, bowel problems, psychosomatic complaints)
Loss of interest in peer social activities

At this age, concern about peer reaction is prevalent. The youngster needs reassurance that his fears and feelings are appropriate and shared by his peers. Adult response should be aimed at reducing tension, anxieties, and guilt feelings. As with younger children, relaxing expectations while still providing structure in terms of chores and home responsibilities is appropriate. Youngsters at this age also need individual attention. Group discussions should enable youngsters to "relive" the crisis as well as prepare for future crises by rehearsing appropriate behaviors.

Adolescence (14-18 years)

Typical responses:

Psychosomatic symptoms (rashes, bowel problems, asthma)
Headaches and tension
Appetite and sleep disturbance
Hypochondriasis
Agitation or apathy
Decline in interest in opposite sex
Irresponsible and/or delinquent behavior
Reduction in struggle for autonomy from parents
Poor concentration

As with pre-adolescents, this age group is peer-group oriented. Of concern to them is disruption of peer group activities. they also look for opportunities to be involve in community efforts. The adult response should be to encourage community participation and resumption of peer group activities. Again, temporarily reduced expectations for school performance is advisable. Discussion about disaster experiences with peers and adults should be encouraged, both inside and outside the family setting.

Referral to Mental Health Professionals

Particularly at risk are children who have lost family members or friends, who have experienced personal loss previously or have been involved in family crises

previously. If normal symptoms persist for may months, referral for counseling is recommended.

Preschool/Elementary

Referral should be considered when the child is excessively withdrawn or does not respond to attention and attempts to draw him/her out.

Junior High/High School

Referral should be considered when the youngster:

--Is disoriented
--Complains of significant memory gaps
--Is despondent or shows agitation, restlessness, and pacing
--Is severely depressed and withdrawn
--Mutilates self
--Uses drugs or alcohol excessively
--Is unable to care for self
--Performs ritualistic acts or is excessively preoccupied with one thought/idea
--Hallucinates -- hears voices, sees vision
--Has the delusion that someone or something is out to get him/her or his/her family
--Is afraid he/she will kill self/another
--Is unable to make simple decisions or carry out everyday functions
--Shows extreme pressure of speech--talk overflows

Suggestions for Classroom Activities

Preschool Activities

- Have available toys that allow children to play out experiences.

- Ensure lots of physical contact as a way of restoring a sense of security. Games that involve physical touching (Ring Around the Rosie, Duck, Duck, Goose) are good.

- Make food and drink (in small portions) more readily available, again, to restore a sense of security.

- Give children the opportunity to draw pictures, do a group mural, dictate stories about their experiences.

Elementary School Activities

- For younger children, make toys available.

- Encourage children to draw pictures, write or dictate stories and then talk about them in a large or small groups.

- Adults can stimulate group discussion by sharing their own feelings.

- Make time available for general discussion about the crisis--ask open ended questions ("What have you been hearing about the war?"). Encourage expression of feelings, correct misperceptions, provide reassurance.

- Give children a sense of mastery and control when possible--give them actions to perform (e.g., writing letters) or provide class activities in which children can organize or build projects (e.g., scrapbooks, art portfolios).

Junior High/High School Activities

- Group discussions which allow teenagers to share experiences, vent feelings are important. Adults can begin by sharing their own feelings. Reassure them the extreme emotions and "crazy thoughts" are normal in times of crisis. Try to end the discussion on a positive note--talk about heroic acts, how we can be prepared for future crises, etc.

- Use small group discussion for the same purposes. Some students are more comfortable talking with peers in this structure.

- For social studies/history classes, provide an historical perspective. Construct a timeline of middle east history. At this age, students are capable of more abstract discussion and can discuss right and wrong, moral choices. Do not promote one view of the war, but make it clear that reasonable arguments can be made on both sides. Stress the complexity of the situation. This is a good time to discuss the concept of majority responsibilities and minority rights. Allowing divergent viewpoints should be an important lesson to get across.

A Model Class Discussion Format

Allen and Anderson (1986) provide a model for a class discussion format that allows children to explore feelings about crises and develop coping mechanisms for dealing with them. The model consists of three 40 minute lessons. The first lesson focuses on defining what is meant by "crisis" and discussing the kinds of crises children experience. It concludes with having children draw pictures depicting a crisis experience.

In the second session, children are asked to write as story about a crisis situation

that happened to them or someone they know about. Those that want to may share their stories or pictures with the class. In the third session, discussion focuses on understanding feelings associated with crises and identifying what actions help them cope with crises. This session concludes with a summary of the main points of the discussion. Children are asked what they learned from the activities.

The authors have used this format successfully with children in second, fifth, and eighth grade classrooms. They concluded, "The discussions were very well received by students and teachers alike. The topic held everybody's attention, there was considerable self-disclosure and a movement, at the end, towards resolution and closure when students were asked to identify actions that help in time of crisis. There was much disclosure of painful experiences but little evidence of a child being overwhelmed. The genuineness of the material shared seemed to activate support and caring from most of the students".

Particularly helpful was the discussion focusing on the question, "What helps you in time of crisis?" Allen and Anderson reported that initially "the students were both surprised and stunned, as if nothing would help. However, once they started talking, they generated many actions steps. Most of these involved talking to parents, teachers, counselors and friends, calling help lines, and such actions as punching a pillow, crying, writing in a journal, talking to pets, relaxing oneself, and praying to God". The older students also relied on their own problem-solving abilities.

Conclusions

The lessons of war are always difficult to calculate. The attention paid to the reactions of children to the current crisis is promising. Children need help sorting out the events that are unfolding and coping with confusing thoughts and feelings. No child in this country will be untouched. It is the responsibility of adults to ensure that their voices are heard, their feelings accepted, and responses provided to their questions.

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RESPONSES TO CHILDREN AND ADOLESCENTS: DEVELOPMENTAL PERSPECTIVES

Scott Poland

TREATING CHILD DISASTER VICTIMS

- Children are resilient
- Family is the first resource
- Children in need of services should be sought out; don't wait for children to initiate the request for help.

PRESCHOOL SUGGESTIONS

- Provide re-enactment
- Verbal reassurance
- Physical comforting
- Encourage expression of emotions
- Re-establish routines
- Allow child to sleep with parents

SUGGESTIONS: AGES 5 to 11

- Patience and tolerance
- Provide structure
- Relax behavioral expectations
- Discussion and rehearsal

SUGGESTIONS: AGES 11 to 14

- Resume routines
- Group discussion
- Group rehearsal
- Relax expectations
- Individual attention

SUGGESTIONS: AGES 14 to 18

- Encourage discussion
- Resume social activities
- Reduce expectations
- Community project

NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS

Children and War—Responding to Operation Desert Storm*

PARENT HANDOUT

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BACKGROUND

With the crisis in the Middle East, your child is experiencing something totally new and potentially quite frightening. American children today have never experienced war as a reality. Our children need support in dealing with this crisis.

Also unique is the impact of the media on our children's thinking. They have been exposed to violence—both real and fictional—in unprecedented amounts since they were born. Violence is replayed on television almost as soon as it occurs, and wars play on the nightly news.

Today's children also live in the world of Star Wars and Super Heroes. Adults may realize Luke Skywalker is fiction, but for children this is not so easy. Youngsters have difficulty separating reality and fantasy. Children who believe in Santa Claus can as easily believe in Darth Vader and Freddie Kruger. Separating the realities of Desert Storm from media fantasy may require adult help. As parents, it is our responsibility to help our children distinguish between fantasy and reality.

EMOTIONAL RESPONSES

Emotional responses vary in nature and severity from child to child. Nonetheless, there are some common ways in how children (and adults) feel when their lives are impacted by war.

- **Fear:** Fear may be the predominant reaction—fear for the safety of those in the military as well as fear for their own safety. Children's picture of war may include a bomb dropped on their home. Their worries may seem unreasonable, but to them, they are quite possible. Children will hear rumors at school and may let their imaginations run wild. They may think the worst, however unrealistic it may be. The threat of terrorism may also add to their fear.
- **Loss of control:** Military actions are something over which children—and most adults—have no control. Lack of control can be overwhelming and confusing. Children may grasp at any control which they can have.
- **Anger:** Anger is not an unusual reaction. Unfortunately, anger is often expressed to those with whom children are most secure. Children may be angry at parents who are in the military to the extent that they do not even want to write letters. Knowing that those who are involved in the military are volunteers only helps to justify anger. Patriotism and duty are abstract concepts, for children, especially younger children, who are experiencing the reality of separation from a loved one.
- **Loss of stability:** War interrupts the natural order of things. It is very unsettling. Stability is gone, and this is very threatening. It can destroy trust and upset equilibrium.
- **Isolation:** Children who have a family member involved in Desert Storm but don't live near a military base may feel isolated. Children of reserve members called to active duty may not know others in the same situation. Such children may feel jealous of friends' undisturbed families and may strike out at signs of normalcy around them.

Another group of children who may feel isolated are dependents of military families who have accompanied a remaining parent back to a hometown or who are staying with relatives while both parents are gone. Not only do these children experience separation from parents, but they also experience the loss of familiar faces and surroundings.

WHAT CAN I DO AS A PARENT?

- Acknowledge your children's feelings.
  - Knowing what to say is often difficult. When no other words come to mind, a hug and saying "This is really hard for you/us" will always work.
  - Try to recognize the feelings underlying your children's actions and put them into words. Say something like, "I can see you are feeling really scared about this," or "It makes us mad to think that our dad had to go to Saudi Arabia," can be helpful.
  - Sometimes children may have an overwhelming fear that they are unable to put into words which you may need to voice for them. For instance, if a parent is away, children may wonder what will become of them if the parent does not return. Try saying, "You never have to worry because we/you will be well taken care of. You won't be alone. Let me tell you our plan. . . ."
  - At times when your children are most upset, don't deny the seriousness of the situation. Saying to children, "Don't cry, everything will be okay," does not reflect how the child feels and does not make them feel better. Nevertheless, don't forget to express hope and faith that things will be alright.

* *The information contained in this handout, though intended to be helpful, does not indicate official sanction or endorsement on the part of the COMMUNIQUE or the National Association of School Psychologists.*

- Older children in particular may need help identifying what they individually believe about war and the role the United States has chosen in this conflict. Questions such as "Could my parent shoot someone?" and "How can anyone kill an Iraqi soldier who is only 12-13—no older than I?" are issues which may need discussion.

- Help your children put their fears in perspective.
  - Acknowledge the sanctity of each human life while letting children know that the chance of any one individual returning from the Middle East is very high. Death rates in U.S. conflicts have steadily dropped from the time of the Revolutionary War to a low of 0.5% in the Vietnam War. With increases in technology and medical advances, military statisticians suggest a potential loss ratio of 0.3% from battle and 0.1% from other causes in the Middle East.
  - Help children to feel personally safe.
    - Discuss what is realistic modern technology versus science fiction. Help children to understand that the longest range missle that Iraq has can barely reach Israel. Discuss how far Iraqi war planes can fly without refueling (about 1000 miles) and the impossibility of refueling anywhere between Iraq and the United States. Let children share their fears, most of which are unrealistic and a result of rumor and anxiety, and put them in perspective as to what is realistic.
    - Help children understand that precautions are being taken to prevent terrorism (e.g. bomb sniffing dogs, passport checks, heightened airport security) which might actually make them safer now than they usually are.
    - Deal with fears such that Desert Storm may be the beginning of the end of the world, or that bombs will reach the local community.
- Try to maintain normal routines to provide a sense of stability and security.
- Help children to feel a sense of control by taking some action.
  - Send letters, cookies or magazines to those in the military.
  - Help your older child find a family who has a parent in the Middle East and arrange some volunteer babysitting times for that family.
  - If a family member is away, make plans for some special activities:
    - Gatherings with other families who are also missing a loved one help provide support for you as well as for your children.
    - Special parent and child times can provide an extra sense of security which might be badly needed. Let your child know that you will set aside a particular half hour each day to play. Make the time as pleasant and child-centered as possible. Return phone calls later and make your child the real focus of that special time.
- Involve children in planning how to cope. Control and ownership are fostered when children help to plan strategies for dealing with a situation.
- Prepare for difficulties with children at night.
  - Maintain regular bedtime routines such as storytime to provide a sense of security. Special stuffed animals or blankets may be especially important right now.
  - Sit near your child until he/she falls asleep for a few nights. Gradually withdraw this support by check back in two minutes and continuing to lengthen this time until your child feels secure again.
  - A light may be needed in or near your child's room.
  - Siblings may want to sleep in the same room until they feel more secure again.
  - Don't let your children focus too much of their time and energy on Desert Storm. If children are choosing to watch CNN News for hours each evening, find other activities for them. You may also need to watch the news less intensely and spend more time in alternative family activities.
  - Use outside support services if your child has a severe reaction. Your school psychologist or counselor can assist or provide names of other professionals trained to deal with children.
  - Try not to let financial strains be a major concern of children. Although economic impact of Desert Storm may result in job cutbacks or going from a civilian job to active duty in the military may cut family income, children are not capable of dealing with this issue on an on-going basis. Telling children that you need to be more careful with spending is appropriate, but be cautious about placing major burdens on children.
  - Take time for yourself and try to deal with your own reactions to the situation as fully as possible. This, too, will help your children.
  - Always be honest with your child and do not be afraid to talk to others about your fears and concerns.

CYPRESS-FAIRBANKS PUBLIC SCHOOLS

PSYCHOLOGICAL SERVICES

PARENTS' RESPONSES TO CHILDREN

Scott Poland

- Should respond with reassurance of safety, love, patience, tolerance and increased availability.
- Parents need to give children permission for their emotions and not project their own emotions onto the child.
- Parents need to understand that the most common childhood response to a crisis is regression. Unfortunately, this regression in behavior may come at the time when the parent is also effected by the crisis and therefore less able to deal with the regression.
- Parents who think that their child is having an atypical or severe reaction are encouraged to call the school for assistance.
- Parents are encouraged to participate in support activities provided by our community.
- Parents should give their children the facts in age appropriate terms.
- Children will differ according to their age in how much they understand this crisis and its relevance to their life.
- Small children should be protected from explicit news coverage should a war begin.
- Provide structure, follow normal routines and encourage participation in play activities.
- Avoid extended television news watching: turn off the television for periods of time and engage in family play activities.
- Answer all questions that your child asks.

Effects of Trauma Still a Part of Everyone's Life

by Betty Spicher

Betty Spicher, a school psychologist in the San Jose, California area, shared her experiences of the Bay Area Earthquake in the November Communique.

It is more than three months after the earthquake that turned out to not be THE BIG ONE. We haven't had a large aftershock for quite a few weeks now and, for those who didn't have much damage in their homes, the emotions have receded and things are getting back to normal. It is, however, very easy to immediately remember the events and feelings of October when our lives were turned upside down for a while – all it takes is a picture, a sound, the sight of a chimney with bricks fallen away, a sudden jolt, or signs of repair along the quake-stricken highway to Santa Cruz.

Immediately After the Quake

Shortly after the quake the media were quick to emphasize that we probably had more to fear! We didn't need to hear that this wasn't the "big one" – the one we had was frightening and damaging enough. Additionally, we were having good-sized aftershocks numerous times a week that kept everyone unsettled and interrupted our sleep. Some of us had a somewhat seasick feeling at times; we were easily irritated, feeling scattered, and with occasional malaise. Many of us were leaving a lot of the household objects that fell during the quake right where they had fallen. People were avoiding freeways because of overpasses they feared being on or under. With each aftershock we would mentally estimate the size of the shock ("this one felt like a 3.5; that one felt like a 4.0"). When one would come in the night I would think of the children and mothers I had been talking with during the week and recall their fears. I was finding it hard to keep on track of what was being worked on before the quake. I had received numerous calls from parents worried about their children's reactions to the quake, and I was doing a great deal of counseling with both parents and children. The testing went by the wayside for a while.

A Week Later

A week following the quake some people still did not want to sleep in the upstairs bedrooms of their homes. An eight-year-old boy didn't want his parents to go to a ball game and leave him to stay with neighbors; he cried and clung to them. A parent came in ostensibly to talk about her child, but we spent more time talking about her own fears. She didn't want to go home with her baby and be alone in her home; she was having an untypical inertia regarding household tasks. Many people gathered supplies, bolted cabinets to the wall and took other measures to prepare for the next blow. At Jazzercize, we responded to Carole King's song lyrics, "I feel the earth move under my feet," as if we were working through our emotions aerobically. Some earthquake "gallows humor" circulated but did not take hold; we were too traumatized. Even now there haven't been many jokes about the quake.

Two Weeks Later

So many people volunteered time, clothing and supplies that the agencies said they had all they could use. Benefits were held to raise money for the Red Cross. Earthquake T-shirts were sold on street corners. In the schools, some teachers were still very fragile and on edge. Children and adults looked anxious with each loud sound or slight move caused by a door slamming. Most of the children I was counseling dealt with their fears constructively, while a few children were still very frightened and a couple of boys seemed to deny thoughts of the quake. In counseling, I reassured children that their feelings were normal and not uncommon. I assured them that they would soon not think about the earthquake that much and that those who had not already moved back into their own beds at home would be able to do so in a few days. At school, some teachers had the children draw their earthquake stories to keep for their children and grandchildren.

Three Weeks Later

Three weeks after the quake I was in a kindergarten classroom where some children were at free play. In the playhouse area some of them were playing an earthquake game where they swept plates off a table, knocked over furniture and yelled *Earthquake!* In a fourth grade classroom boys shook their desk-tables and yelled "Duck and Cover" (California's earthquake drill procedures for students). When a large aftershock occurred during a late afternoon support staff meeting, a woman lurched and gasped, scaring the rest of us more than the actual aftershock. I discontinued counseling a couple of children when I got the feeling that they were using their continuing expressions of fear to get attention, but I told them to have their teacher contact me if they needed to talk. Parents whom I contacted to check on their children's progress reported that the children were doing quite well.

Children's Drawings

As I worked and talked with children in the weeks following the earthquake, I had them do a drawing. The first time I saw them I had them tell me about what happened to them during the quake and then draw a picture of it. When I met with them after that I just asked them to draw a picture, and many children drew pictures of the earthquake again. It was interesting to observe the pressure with which they drew. The first drawings were always done with very heavy pressure causing dark, broad, repetitive lines. Subsequent drawings generally revealed less pressure and repetitiveness which seemed to be an indicator of lessening anxiety. That, as well as the nature of the drawing and the story about it, gave me cues as to when to discontinue seeing a particular child.

Most children needed to be seen only several times over the first two weeks after the earthquake. However, Sandi, a second grader whom I first saw three days after the quake, continued to express intense fears, and her drawings were reflective of her anxieties. She had moved back into her own bed Thursday night following the Tuesday quake, but she expressed great fear. As she drew a picture, she pressed down so hard the pencil lead broke. Her first drawing was of jagged lines around a hole (she seemed to get some release from repetitive drawing of lines). In the picture she was lying in the hole calling "Help". She said she was afraid that a hole in the earth would open up and swallow her. A week after the quake Sandi was very intense as she drew a house and nearby car with herself standing next to the car while rain and bolts of lightning were all around her. She said the house was about to fall down because of the earthquake and she didn't want it to fall on her. When I asked how she could get out of the rain and lightning, she said the car was locked and her mom had the keys, but she decided she could go to a friend's house. When I talked with Sandi's mother she revealed that her daughter still jumped at every unusual sound and would get under a table. The frequent aftershocks were traumatizing for her. The mother said that things were better that week although for the week following the quake Sandi followed her mother around and would not go to the bathroom alone.

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Sandi's drawing two weeks after the quake showed a car going across the Bay Bridge during the quake. Her story was that her mom and dad had flown out through the car's front window into the water while she and sister stayed in the car which fell into the water. No one was saved, she said. Three weeks following the quake Sandi's drawing showed her and a friend ice skating. She related that an earthquake occurred and the ice started to break up; the girls ran home and Sandi slept in her mother's room that night. Around this time, Sandi saw a television program on earthquake preparedness which helped her deal with her anxieties and regain some sense of control as her family took some of the measures recommended.

A drawing done a month after the quake showed Sandi in a shopping mall during the earthquake. She calmly related that she stayed in one place until the quake stopped and then went outside and got away safely. Pencil pressure was much lighter and her manner less anxious. Her mother reported that Sandi seemed much more stable, so I discontinued seeing her.

Conclusion

Counseling during this type of crisis situation was a new experience for me. I was thankful that no sizable aftershocks occurred during school hours, so in the students' minds the school was seen as a safe place to be. Most children were referred to me by their parents; very few were referred by teachers. About one-fourth of the parents reported that their children had emotional difficulties or behavioral problems prior to the quake and that the quake exacerbated their functioning. Several children were referred to private counselors for therapeutic intervention. Several weeks after the quake most children at school showed no signs of anxiety in class or on the playground. When asked if most kids on the playground were talking about the earthquake, my counselees said they were not.

It was important to me to validate all the feelings of each child and assure them that they were having a normal reaction to a frightening experience; I shared with them that it had been frightening for me too. I corrected some misinformation and mistaken impressions, particularly regarding a media report that the "big one" was still to come. I told the children that I have lived in the Bay Area all my life as has my 75-year-old father, and this was the biggest quake we have felt (and thus it may be the biggest one they will every feel). I assured them they were making good progress in dealing with their fears, and I encouraged parents to return to a normal routine as soon as they could to give their children the message that life goes on and is stable and predictable for the most part. A trauma like an earthquake makes us appreciate what we have, to value our relationships with each other, and to not take people and things for granted. If children can learn this from such a frightening experience, then it may stand them in good stead throughout their lives.

Betty Spicher is a school psychologist with the Oak Grove School District in San Jose, California.

Effects Last Even When Sun Shines

by Jan Harlrom

I am a school psychologist in Georgetown County, South Carolina, in a school district serving about 10,000 students. Georgetown is on the Atlantic coast between Myrtle Beach and Charleston, an area devastated by Hurricane Hugo. What follows are some of my experiences just prior to and following Hugo's arrival on the night of September 21.

Although the "storm", as many locals call it, sustained winds up to 135 miles per hour with accompanying tornadoes, the most damaging part for coastal residents were the tidal surges which reached 20 feet in some areas. McClellanville, a small shrimping town of 500 residents 25 miles south of Georgetown, was especially hard hit.

I became aware of Hugo about four days before it reached the South Carolina coastline. As the storm approached, media coverage intensified, hurricane tracking maps became available, and grocery stores packed "hurricane preparedness tips" in each grocery bag. Tips ranged from purchasing items such as flashlights, batteries, nonperishable goods, to collecting water. Still, many people were poorly prepared for Hugo's arrival.

At the beginning of the work week, I sensed I was more concerned about the approaching storm than many of my friends, particularly those who had lived along the coast for some time. I learned late Wednesday night that school was canceled for Thursday and Friday. I had already packed what I considered to be "essentials" (television, stereo, pictures, important documents), hitched my sailboat to my car and prepared to leave first thing Thursday morning.

It rained heavily Wednesday night and I did not sleep well. The next morning the trip inland took four hours instead of the normal two-and-a-half hours because of all the traffic moving inland. I was unable to return to my apartment on Friday following the storm because of impassable roads. Not knowing the condition of my belongings was a horrible feeling; I was anxious and sad and assumed the worst. I vacillated between denial (everything is fine) to hopelessness (how will I replace all I have lost). I began to question my reasoning, regretting, for example, that I packed a television instead of the rest of my clothes.

I returned to Georgetown five days after the storm. Although the town was functioning with limited electrical and telephone service, there was a mandatory curfew and armed National Guardsmen patrolled the streets.

Many McClellanville residents had fled to the local high school which was being used as an evacuation shelter. Tidal surges destroyed their cars, shrimping vessels and homes. Lives were threatened by rising floodwaters, forcing people to stand on upper bleachers in the gymnasium of the school to remain safe from the cold water. Many residents were bussed to Georgetown, and some were evacuated to yet another shelter, all within a 48-hour period. Many appeared to be in a state of shock, numbness and denial, later appearing to approximate Kubler-Ross's stages of death and loss.

My first day as a volunteer at a church in McClellanville where about 100 people were staying, I noticed 25 children with nothing to do. After a phone call, toys began to arrive from my colleagues, temporarily making the children happy and easing their pain. Many school district employees arrived; and offered support and Mental Health Center personnel visited daily to provide counseling to those in need.

The shelter was managed the first two weeks by a Red Cross volunteer, a psychiatric social worker with previous emergency experience. Initially I thought she was somewhat aloof or distant to those coming to the shelter, but I quickly realized her emotional distance was necessary to make this extreme situation into a manageable task. However, I had to blink back a tear when I saw an older woman (perhaps a grandmother) with a small boy about 10-years- old, inquire about socks for the boy, who was barefooted. She was turned away because she was not a McClellanville resident (although she was given information about how to obtain needed items). The woman silently shed a tear, and I offered informational assistance. Although the shelter manager was following procedure, I will never forget the look on that woman's face nor her tear as a result of her denied request.

After my first day, I suggested to Men-

tal Health personnel and school district administrators that we add structure to the children's day. The children, who ranged in age from three to twelve years, appeared to enjoy their new "routine" and responded well to "school time". They spent approximately one hour engaged in relatively appropriate academic work; such as computing math problems, which seemed to provide them some security and an idea of what was to happen next, tomorrow, etc. I was told later that they continued this routine over the weekend on their own when I was not there.

Most of the daily activities gave the children opportunities to talk about their experiences, allowing them to laugh, cry and console one another. They particularly enjoyed playing with Play-doh and Legos and drawing (before and after Hugo pictures of their homes and possessions). Some children built homes with Legos and then knocked out walls or otherwise destroy them as Hugo had done to their homes. Several children who were given sand to play with poured water on the sand to represent tidal waves.

A decision was made that the students would attend school in our school district while their schools and homes were being repaired or rebuilt. One crying child described to me his experience during the storm. He and his family, which consisted of both parents, two siblings and a grandfather in a wheelchair, remained in their home during the storm. As the boy told the story to me, he kept repeating how dark it was (this variable added to his trauma). The electric companies had indicated power would be shut off when sustained winds arrived because downed power lines would pose additional hazards. Water crept under the doors and rose rapidly. The father was the only swimmer, he said. The family climbed to the attic, with the mother assisting the grandfather to float up the stairs to the attic as the water rose. After staying in the attic all night, the father carried the grandfather in waist- deep water to rescuers who took him to a hospital. He caught pneumonia and died approximately a week later.

Communication between the school and McClellanville parents was good. When problems arose, parents and other adults at the shelter responded as necessary. Getting enough sleep was important for the children and teachers were concerned that students were continually tired and often fell asleep within a few hours of arriving at school. A reasonable, routine bedtime for all elementary students was the answer with a designated "lights out" providing needed structure and routine.

The children's emotional adjustment was like a roller coaster, with "good days" when they were typical kids to "bad days" when they cried and needed counseling. The guidance counselor did an excellent job of providing counseling services. I checked on students each day when I was at the school and visited the shelter frequently to talk to parents. In most cases, McClellanville students withdrew from Georgetown Schools after two weeks.

While there is no way to be fully prepared for a disaster of this magnitude, the school district took appropriate measures by holding a district-wide meeting to plan for the needs of the students. Additionally psychologists and counselors were provided information on crisis/trauma reactions and given an awareness of planning interventions in such instances. The compassion and genuine concern displayed by administrators and teachers was commendable.

Although shelter living can be very stressful, I noticed little incidence of interpersonal difficulty. This may be due to the fact that residents reported knowing almost everyone in their community. However, with such a lack of privacy and such major inconveniences as scheduled times for shower facilities, such harmony was surprising. In addition to fellow residents, people living in the shelter had to endure visits from "well wishers" and the curious who came to the shelter. Future planning for such disasters should include ways to protect the privacy and dignity of the victims.

A final concern involves the concept of learned helplessness. As time progressed, adults with no responsibilities appeared bored and depressed. Perhaps our efforts to take charge reduced the personal control these people should have had on their own lives. A future consideration would be to see victims as *survivors*, allowing them to administer to their own needs to the extent possible. This could include food preparation and cleaning duties.

Although donations and assistance continue to arrive, it is important that we remember these disaster victims as time passes, especially as the holiday season approaches. Hugo temporarily altered my life, leaving a lasting impression. I am glad that I, and many others, have had the positive experiences and will profit from the personal growth that may not otherwise have taken place.

Winnetka: One Year Later

It was one year ago that a woman walked into a Winnetka, Illinois school and irrevocably changed the lives of hundreds of children and adults. What follows is an accounting of the event, the mental health efforts extended to cope with what turned out to be a tragedy, and the ongoing community and personal impact. Harry Dillard, a school psychologist, was and is the Director of Pupil Services for the Winnetka Public Schools. This article was coordinated by Laurie Kilpatrick, Communique Contributing Editor.

by Harry Dillard

On May 20 of last year, a shooting rampage by Laurie Dann forever changed the safe, protective atmosphere of Hubbard Woods School in Winnetka, Illinois. The following are my reactions and my response and that of the school's staff with the hope that this accounting will help other school staffs, children and families that have recently been terrorized by maniacs.

I had just returned from a parent conference at Hubbard Woods and was settling into my office at the administrative center when the secretary from Hubbard Woods called and said, "There has been a shooting at Hubbard Woods; six kids are down. Bring all the nurses and social workers."

My mind raced as I tried to imagine what I would encounter at Hubbard Woods. My first thoughts were about the first aid I learned too many years ago and then about psychic trauma. As I arrived from the back of the school everything looked normal until the wailing of a siren and the rapidly departing ambulance from the front of the school confirmed the reality of that fatal call. Running toward the school, I was suddenly stopped by a policeman blocking my view and asking what business I had at the school. Without breaking stride I yelled that I was the school psychologist and my staff and I were on our way to help the kids.

Somehow without knowing where the shooting had occurred I ran past the front door of the school. The paramedics were placing a stretcher into an ambulance and a mother I recognized was climbing into the van. As I entered the outside door of room seven and saw a child covered with a blanket, paramedics at his side, and another child bleeding but being bandaged by paramedics; there was the illusion of control. Then I saw a baby of a boy fetally curled up, struggling to breathe, his nose and mouth covered with an oxygen mask. He was shaking as if he was in the midst of a convulsion surrounded by black, darkening pools of blood on which little pieces of paper toweling floated.

My senses were being flooded and threatened to overwhelm me. Within moments, as the paramedics again worked feverishly over this helpless, critically wounded boy, I realized that my limited first aid skills were not needed, and the psychological work began.

A Horrible Day

It was a terrible, horrible, no-good, very bad day. It was this phrase from Judith Viorst's book, *Alexander's No Good Day*, that Hubbard Woods Principal Dick Streedain used with the children as he and Dr. Mary Giffin of the Irene Josselyn Clinic went from classroom to classroom to explain what had happened early that Friday morning. The feelings the children, staff, parents, and trauma team experienced forms the central feature of Post Traumatic Stress Disorder (PTSD). DSM-III-R defines the core experience of PTSD as a person having "experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone."

Stockton Shootings

I don't think we knew how close these feelings were to us at Hubbard Woods School until the shooting at Cleveland School in Stockton, California. On January 18 of this year the administrative and teaching staff at Hubbard Woods school met to discuss how our children were doing. The purpose of the meeting was to plan time for the children to discuss the events in California and to sensitize ourselves to symptomatic behavior that we might observe in the classroom. During this discussion, one teacher described a feeling that summer had not intervened and that it again felt like the end of May. Prior to the shooting in California, she and her colleagues had felt that all seemed better and that life was taking on a more normal sense.

M. J. Horowitz (1986) in his book, *Stress Response Syndromes (2nd Ed.)*, proposed an information processing model for dealing with the aftermath of an event that impacts so heavily on an individual and his surroundings that he feels changed. In this model Horowitz incorporates our normal need for closure. He proposes that until a traumatic event can be mastered through understanding and then integrated, its psychology is stored in our active memory. As mastery occurs, the trauma is incorporated and the details fade from immediate memory. At completion the traumatic experience has become a living part of our persona and our world view. Until this mastery occurs, the children, staff, parents, and trauma teams are vulnerable to psychic overload where normal ego coping mechanisms are not up to managing the stress produced by a tragedy. Horowitz developed his model for adults and while it may not fit children as well, some of the children's stories produced during the aftermath of the trauma suggest that the model does have value for understanding and differentiating between a normal and a pathological response. Stories from children close to the shooting conveyed the sense of being overwhelmed by fear and anxiety expressed in many victim metaphors. The Horowitz model is developmental in that anything can go wrong at any level. Maladaptation becomes a question of degree which is defined by frequency, intensity, and the prolonged nature of a response. Our experience is that almost all of the survivors at Hubbard Woods experienced at least some aftereffects. The norm is a mild PTSD reaction as recently gleaned from 62 completed child interviews.

Children Coping

Being able to identify the event as likely to evoke significant distress in almost anyone–which is central to a determination of PTSD–was in fact the norm for students at Hubbard Woods School. The children are able to imagine that the life threat would be extremely upsetting to most other children. Some of their written statements include: "Baby-sitter aren't suppose to shot and kill kids," "It was the scariest day of my life," "It will never be the same." The following story from a boy who saw Laurie Dann just before she shot five children in the second grade class provides a glimpse into

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the horrible threat that the children experienced. (Names are deleted.)

"On Friday were gong to fly are kiets. A lady came to the school and came to the ferest boys bathroom and the secounet boys bathroom and ( ) hab to go to the bathroom and I saw the lady pulled ( ) by the hand and I had to go to the bathroom with ( ) and me. ( ) pushed the door on saw ( ) on the floor. I saw the lady with the gun I ran to my class room and the lady ran to the other classroom and shot 5 kids."

Nine months later this same boy produced the following story in writing a letter to the children at Cleveland School in Stockton, California.

"Hi my name is ( ). The shooting that happened here was scary. One of my friends was in the bath room. Me and my other friend had to go to the bath room. I heard two ballet shots. I saw the girl and so did my friend ( ). I told my teacher she told us to go under the table. She ran out the door. But before that we were going to fly our tites. I guess we did'nt. Be now I feel better. You know you will feel better. You'll smile an giggle. You'll have lots and lost of fun you know. This is me. I look great. I'm in second grade. I'm 8 years old. This is how I look."

These stories show the changes which have occurred with the passage of time, emotional support, and counseling. The experience remains a scary event as part of his life's experience; however, it is no longer as overwhelming to him. Life has taken back on its playful content as it should with an eight- year-old.

In reporting the trauma children typically described the event as a specific vivid image or sound related to the violence or its aftermath. One child wrote in her journal, "When I work on my homework it's usually late because of after school activities so I get scared on mirrors, china, because I'm afraid it will shatter in the sound of a gun. It makes me feel almost dumb."

Another child went on to report in his journal, "When I go to sleep I usually, breath real loud and move around a lot because I don't want to picture Laurie Dann's face or hear a gunshot."

Children's dreams incorporated direct reenactment of the specific violence and/or depicted fears of recurrences of other forms of violence or life threat. Children in the line of fire reported dreams in which they were again under direct fire or witnessing injury to the other kids. The action was vivid, with little elaboration and accompanied by a strong feeling of life threat. The dreams of less exposed children more commonly manifested general fears of recurrence. Numbing of responsiveness, reduced involvements with others and activities were evident as the children described a lessened interest in some play or in using the washroom for social purposes. Some felt more distant from their parents and some did not want to remember their feelings. Our preliminary work with the children at Hubbard Woods also showed some children being hyperalert and vigilant, feeling helpless (anxious/depressed), reporting guilt feelings about not being shot, and expressing some difficulty with concentration and recall. Sleep problems were typically reported by their parents.

The research of Pynoos et. al. (1987) provided strong evidence that acute post-traumatic stress symptoms result from violent life threat and the severity is related to the extent of exposure to the threat or the witnessing or injury of death. Proximity is a key which we have seen over and over again in various forms. More than half of the Hubbard Woods School families came to an informational meeting on PTSD symptoms while less than one percent of the families from the other three schools in the district came to the same presentation the following night. About 80 percent of the Hubbard Woods professional and para-professional staff and about one percent of staff from the other district schools registered for the assessment of post traumatic stress offered by Evanston Hospital. The Hubbard Woods' staff and families experienced the Stockton shooting at a much more intense level than staff and children in other neighborhood schools.

In order to differentiate between a disordered and a normal stress reaction, two factors besides the presence of DSM III-R criteria for a post- traumatic stress disorder need to be considered. The degree of control the person has over intrusive or repetitive thoughts and how severe the impact is on spheres of functioning, such as school and work performance, peer relations, and fun activities are meaningful. Pynoos et. al. (1987) found that the most exposed children showed a loss of interest in play and other usually enjoyable activities, feeling more distant from their friends and parents and/or more alone with their feelings, and not wishing to be aware of their feelings. A persistent sleep disturbance and difficulties with concentration most differentiated severe reactions from moderate ones. Knowledge of the victim and feelings of guilt also increased the intensity of the reaction.

With the children at Hubbard Woods School we look at them in the broadest way possible. We look at what it feels like to them in terms of their relationships with other kids, in terms of their ability to let a parent or teacher know how they are feeling. We look at whether or not parents think things are different to them with their kid. We would like to know if their level of functioning has changed. With some of the families that have called me, I hear about kids who are unable to sleep and relax, some who have not calmed down enough to relate to other members of the family, some who are finding it hard to stay in their bed at night and some who need to have the lights on. We want to know whether something feels quite changed. Some kids are naturally not very verbal and some are extremely verbal. Preliminary information from the screening of about 70 children for post-traumatic stress during late January and February showed that the norm is a mild PTSD reaction. About 56 percent of the children showed a mild reaction while five-plus percent of the students exhibited significantly altered behavior attributable to the shooting. These were children close to the epicenter of the tragedy. Future reports will detail information about the screening procedures, process and results.

How the Winnetka Schools responded to the tragedy paralleled many of the treatment approaches for the Vietnam veteran described by John Wilson in *Post-Traumatic Therapy and Victims of Violence* (1988). Recollection of the events triggers memories of the trauma team from Evanston Hospital supporting the superintendent, principal and psychologist by telling us that "You're doing okay." This outside support that the decisions being made were on target while we were attempting to master our own traumatization allowed us to move forward with confidence even if it was a bit shaky. We found that for the decision makers suggestions to take care of oneself, empathic listening, and useful information about trauma and its path were most useful. The attitudes of the families and friends within the Winnetka community toward the school and its professional staff was critical to the healing process. All but a few families out of 300 families of Hubbard Woods School attended the meeting at the school on Saturday, May 21, 1988. The media's reporting of the shootings and the aftermath was rich with praise for the school district's management of the aftermath. Families were feeling comforted with the flow of information, the institution of security measures, the availability of counseling for the students, the presence of a seemingly never depleted staff. Community groups

provided the staff with lunches and take-home dinners almost until the close of school so that the staff could stay together and support each other and not be pressed with routine family demands. A micro-perspective on our response during the first week hopefully will provide useful information for those who may face a crisis.

Events from May 20 to May 27, 1988

Friday, May 20

10:45 a.m. Laurie Dann enters Hubbard Woods School and takes a first grader walking down the hall into the bathroom and shoots him with a .357 Magnum. Two boys discover her. She points the gun at one, and he hears the hammer click but the gun does not fire. As his friend runs and tells his teacher that there is a woman with a gun and that a boy has been shot, Laurie Dann enters a second grade classroom and shoots five children at point blank range, killing one. She then leaves the school.

11:15 a.m. Decision is made to keep children inside the school. Kindergarten children are not dismissed as the assailant remained at large. The superintendent determined that school was the safest place for the children. Mental health professionals from the community begin to arrive. These resources are assigned by psychologists to teachers and their classes. Some are assigned to work with families outside school. The decision to keep children in the building is conveyed by the superintendent to the families. The superintendent was the single spokesperson for the district: he told the families what had happened, what the children has seen or heard, what the professional staff had done and the status of the children's psychological state.

Comments from a parent: "I felt they were there to help and support me. I felt all I had to do was follow them."

11:15 a.m.-2:15 p.m. Children are counseled in their classrooms by teachers and mental health professionals. As information was being received and confirmed it was conveyed by the principal, resource center director, social worker and psychologist going to each classroom to talk to teaching staff and children. Plans were made by the superintendent, board of education, principal, director of pupil services, and police chief on admitting parents to the school.

2:45 p.m. Parents are admitted to the building by class. They are checked by staff and parent helpers to screen out nonparents. As parents enter through the school's front doors, there are representatives from the board of education, administration, and PTA, as well as a uniformed policeman and a clergyman. The children are brought by teachers and psychological support staff to the auditorium to be reunited with parents. Parents are informed of what the children in each class had seen or heard (that is, what we knew at the time) and given information on what to expect and that the school would be open on Saturday. They are asked to come with their children.

3:30-5 p.m. Mental Health personnel are assigned to each classroom. Plans were being made for Saturday by the superintendent, principal, and director of pupil services. The news of Dann's suicide allowed the second grade classroom to be cleaned up.

7 p.m. An all-village meeting is held at the Community House. Multiple group meetings are chaired by psychologists and psychiatric nurses, resident physicians, and psychiatrists from Evanston Hospital.

10 p.m. The principal and school psychologist visit hospitals.

Saturday, May 21

1 a.m. The principal and school psychologist review plans for the morning.

7 a.m. Staff meets at Hubbard Woods School.

10 a.m. Parents and children receive group counseling in classrooms.

1:30-3 p.m. An administrative meeting with all principals is held.

Sunday, May 22

1:30-3 p.m. There is a meeting of the superintendent, principa', PTA president, psychologist, and social worker.

Monday, May 23

7 a.m. A faculty meeting is held.

10 a.m. School is closed for the funeral.

11:30 a.m. Faculty support session and lunch is held in the building.

1 p.m. Children return to school.

2:30 p.m. A memorial service is held in the auditorium.

3:15 p.m. School is dismissed.

Tuesday, May 24

7 a.m. There is a faculty support session and announcements. The day is spent counseling students and with parents.

There is a full day of school.

7:15 p.m. The Board of Education meets.

Wednesday, May 25

A full day of school is held.

10 a.m. There is a parent meeting in the auditorium until lunch dismissal.

7:15-11 p.m. Parent counseling sessions are held at Hubbard Woods School.

Thursday, May 26

The presence of the press has begun to diminish. News of a possible accomplice of Dann surfaces and causes alarm. Drawings made by the children show the impact of media presence on the children.

Friday, May 27

Anniversary reactions: Children show heightened stress. Student and parent counseling continues.

Summer Activities

By the end of school during the second week of June, a small group of school and hospital personnel had formed a working alliance and were developing plans for the summer. This group included from the school system: the superintendent, the school psychologist, the principal, and two board members; and from the hospital: the chairman of psychiatry, the child and adolescent psychiatric chief, the chief of behavioral and developmental pediatrics, and two clinical psychologists--one from psychiatry and one from pediatrics. Three evening meetings were held at Hubbard Woods during the summer. At these meetings we had several of the classroom teachers, the principal, the school psychologist, the school social worker, the chief of child and adolescent psychiatry, the chairman of psychiatry, and the director of the inpatient child and adolescent unit. These meetings served a support function.

The parents attending were encouraged to talk about how things were going with them and with their children. A part of the meeting was set aside for responding to the current rumors. The meeting closed with some general information about how the victims of the shooting were doing and some information about grief and stress. At these meetings, a need for screening was being voiced as families questioned whether behaviors such as separation problems, fear of strangers, and fears of being hurt were important enough to warrant professional consultation; although there was apparent fearfulness about the research motives of the hospital.

A New School Year

In September 1988, as this school year began, we involved several of the friends of the victims, the mother of one victim, and two parents--one a clinical psychologist and one a social worker--to work with the school and hospital team in discussing the needs for a screening of children. At this meeting, we discussed the literature (Blom, 1986; Lindy et. al., 1981) that points to the reluctance of those most in need to use the assistance being offered, which is called a *trauma membrane*. After one meeting of this joint undertaking, the parent representatives wanted the community to have available the literature on trauma, grief, assessment, and human resources. Six inches of Xeroxed articles were organized in notebooks that were placed in each school, the administrative office, and the public library. A teacher inservice training on signs and symptoms of stress and two parent meetings were held on January 12 of this year to discuss the voluntary aspect of the screening and to display a videotape of the actual child portion of the screening. The screening process began on January 25. What have we heard during the screening from our children?

Our kids are reporting a lot of anger at being told that it would never happen again and then hearing about the shooting at the Montifiore School in Chicago; the killings at the school in Greenwood, South Carolina; and then the sniper attack on the child in the schoolyard in Florida. This all happened in the first six weeks of the new school year. Since I initially started work on this article, we have also experienced the tragedy at Cleveland School in Stockton, California.

At Hubbard Woods we see parents saying that everything is okay but then reporting that their children are not sleeping very well, having nightmares, or they are sleeping with their siblings or parents. We see a boy who burst into tears when he saw a stranger on the playground. We see kids who don't go into the bathroom to socialize and one little girl who soiled herself because she didn't want to go to the bathroom at school. We see a fifth grade boy who is already concerned about the anniversary. The kids are showing some fears of repetition, both of the event and of the feelings associated with the event. They and their parents are fearful of the loss of control. Once their feelings emerge they are afraid that they won't be able to control them. They need to learn how to express their feelings again.

There is shame and rage at being vulnerable. There is also sadness and depression over the loss. The bereavement that follows the violent loss of a childhood friend can be a serious emotional challenge for a young child. When you lose a parent you lose part of your past; when you lose a child you lose part of your future. It goes against the natural order of events. In contrast to adults, children are confused, frightened and disturbed by their normal grief reactions. They don't know that they are supposed to feel the way they do. Furthermore the capacity of children to sustain sadness is not fully developed. The lack of a sustained manifestation of sadness may also prevent parents from appreciating the nature and intensity of the children's grief reaction. After the Stockton shooting, we again met early in the morning with the faculty; and then the principal and I had an open meeting for parents who wanted to come to the school and talk. We anticipated that 20 parents might come. By 9:30 a.m. about 75 parents had arrived. What they wanted was a 20- foot-high brick wall built around the school and playground and an armed guard for the hallway. The events and threats remain closer to the surface than one on the outside can imagine.

Preparation and Response

What do you do to prepare for and respond to such a terrible crisis? Our experience and the work of Nader and Pynoos and Project C.O.P.E. (1986) provide some guidance.

*** *Establish relationships with mental health resources, police and fire departments in your community.* Assess the mental health resources available in a crisis and how to call upon those resources. Identify contact people in the mental health agency or hospital. Develop a contingency plan with the police and fire departments. Have paramedics in-service school staff on what to expect in an emergency.

*** *Provide psychological support and on-going counseling.* Provide immediate psychological services on or near the site of violence. This can provide an important feeling of immediate relief. Use of the classroom setting was an ideal place for consultation and counseling as it helped to reestablish for the children the school as a place of security. The school psychologist is a key person in identifying counseling needs and working with the school, community and private resources to provide treatment for victims. The school psychologist can be the bridge among different groups of concerned adults.

*** *Establish a procedure for rele ing children to their parents when safe has been established and some sense calm has been restored.*

*** *Provide clear, direct, honest i formation to parents, staff, and childre* This serves to create trust by reducir panic, suspicion and alienation.

*** *Have one person act as th school's liaison with the media.* Try avoid the limelight. State the facts as on knows them. Use the media to prese the message of restored safety and secure environment for the childre Discuss plans that will promote healir and mastery of the trauma.

*** *Keep the school open for info mation and counseling.* Counseling an nursing offices should be open students, parents and staff. Consultatio during the initial stages of the aftermat of a crisis will build trust and cooper tion for a more thorough consultation a later date. Visibility of school perso nel, especially the superintendent an the principal and other staff in charge important. The superintendent as th chief executive officer of the schoo district is especially critical to set th tone of trust.

*** *Plan for staff counseling an guidance.* The staff, like the children need time to tell their trauma story. Con sultation and counseling services nee to be provided for teachers. Staff shoul have the opportunity to be assessed fo PTSD and to participate in a time limited, focused group. Informatio about post-trauma stress symptom should be provided. They need to know what the common behavioral and schoo performance changes are that may oc cur with PTSD. Teachers may need ad ministrative permission to allow the af fective fallout from the crisis to become their curriculum. Also proper handlin of information about the injured classmates and their reentrance into class is important.

*** *Use group meetings to convey factual information and dispel rumors.* School-wide meetings where parents questions can be listened to and answered is a good forum to assis parents in helping themselves and their children. We found that children were likely to do better than their parents in discussing their fears and feelings about the event. Adults need to be encouraged to keep open discussion about the tragedy. They may want to put it in the past before the fears aroused by the trauma have been mastered.

*** *Develop plans for the anniversary reaction.*

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Early Intervention In A Disaster: The Cokeville Hostage/Bombing Crisis

Editor's Note: On May 16, 1986 shortly after 1 p.m., David and Doris Young entered and forcibly took over the Cokeville Elementary School, holding as hostages approximately 160 students and adults. According to reports from the conversations of the hostage-takers and the principal, David Young spoke often of starting a revolution to solve societies problems and demanded $2,000,000 per student to help finance the revolution. Sometime after 3 p.m. David Young left the classroom in which the hostages were being held and his wife accidentally triggered an explosive device which fortunately failed to completely detonate and explode. Nevertheless, the explosion injured approximately 80 persons including Mrs. Young. As the hostages ran from the building David Young returned to the room and recognized his plans were finished; shot and killed his wife and then himself. The terrorist incident was over shortly after 3:30 p.m. Approximately 60 parents have been involved in formal counseling services in the aftermath of the incident and 40 cases terminated as of August. The following item by Dr. Nohl Sandall was requested by the editor after Sandall appeared on NBC Nightly News. The editor also had the opportunity to interview him during a summer visit with the Wyoming School Psycho-educational Association. Dr. Sandall is a social psychology graduate of Brigham Young University and a licensed psychologist in Wyoming employed by Lincoln County School District #2 which includes the Cokeville Elementary School.

I appreciate the opportunity to prepare this article concerning the Cokeville hostage/bombing crisis of 16 May 1986. Cokeville is a rural farming community in extreme western Wyoming. There are about 500 people in Cokeville and another 500 in outlying areas. It is approximately 150 miles north and slightly east of Salt Lake City, Utah, and 130 miles south of Jackson, Wyoming. The elementary school has approximately 150 students and 15 faculty and staff.

My first contact with Cokeville began in the fall of school year 1981-82. I was hired by Western Wyoming Mental Health Center as staff psychologist at North Lincoln Clinic and later (1982-83 and 83-84) as Clinic Co-ordinator. Lincoln County School District #2 purchased my services 4 days weekly, one of which was spent in Cokeville. Previous to 1981, I served as director of a regional educational service center in southeastern Utah. I had also been on staff of the University of Utah as project director of the federally funded (US Office of Education-Bureau of Education for the Handicapped) demonstration projects, site co-ordinator for USOE-BEH project, and worked 5 years at Utah State Hospital in Provo, Utah. I have also taught several graduate and undergraduate courses for several colleges. I received my Ph.D. from Brigham Young University in 1979 and am currently a licensed psychologist in Wyoming, practicing in the Afton, Wyoming area. Duties for the school district before 16 May 1986, were common to those of many school psychologists, i.e., assessment, counseling, working with teachers and staff and responding to PL 94-142.

It is difficult to imagine school psychologist roles changing as dramatically as they did in the aftermath of the Cokeville bombing—virtually impossible to plan for. By late Saturday, May 17th, the decision had been made that I would co-ordinate and manage the intervention in the aftermath of the crisis. At this point a need to define limits emerged. We also had to begin to establish priority concerns to be addressed. The role of psychologists in the school began to include crisis management, community organization/relations, media liaison, staff co-ordination, and group facilitator.

Still later Saturday evening, the FBI, Bureau of Alcohol, Tobacco and Firearms and local and regional law enforcement had returned the building to school officials. Law enforcement had also adopted the view that David Young had acted alone as opposed to part of a large group such as Posse Comitatus as was at one time suspected. This information allowed us to plan when to return to the school and to know whether there was need to be concerned about reprisals of any sort from some other group. Another issue was how to impact as many residents as possible in an appropriate and productive manner.

Town Meeting

Because in Cokeville much civic activity centers around the school, as early as Saturday evening, Principal Max Excell and I were moving toward a town meeting plan. Tentatively, this was planned to occur Monday afternoon with smaller group follow-up sessions to follow. Because of the uniqueness of the incident, the purposes of the meeting were to: a) provide information regarding expected reactions and how to respond to and deal with them and, b) begin to establish as open, receptive, and supportive atmosphere as possible and to encourage free expression about the incident.

We received broad support for this course of action. Victims of the Chowchilla bus burying incident had been told to return to their homes and to forget about what had happened to them and only a small percentage of them would ever develop any symptoms. Subsequently, a 4-5 year follow-up deomonstrated 100% with clinical symptoms. Dealing with the incident by denying it did not seem the best course to follow (Terr, 1983). Also, Mr. Henry Tarke of San Ysidro, California, emphasized the value to "rehearse, rehearse, rehearse . . ." (Tarke, 1986).

Because Cokeville is a very close knit community, we felt it advisable to involve local and regional counselors in the follow-up. We felt that perceived proximity and perceived commitment to the area and community would be invaluable in encouraging openness. We felt further that inviting in counselors from out of the state or region may have had the effect of inhibiting free expression of concerns and questions. Again, this view was supported and we felt our own perceptions were confirmed in terms of the direction in which we should move.

The Facility

An issue that had to be addressed was management of the building, including the room where the incident had occurred. As early as Saturday night, some children were asking to go back into the room. Our decision was to allow access to the room for the following reasons: a) To disallow access to the room would be inconsistent with the main focus of an open atmosphere about the incident. b) To disallow access to the room invites questions as to why and speculation as to how bad things must be that people couldn't even go back to the scene to examine it. c) To disallow access goes against Tarke's (McDonald's Massacre) advice to rehearse. d) To allow access was felt to maintain openness, communicate faith in individuals' ability to deal with the situation, eliminate ambiguity about reality of the situation, and allow residents and student victims to begin to reestablish ownership of the building.

In extensive discussion with individuals as they moved through, interacted in, and emerged from the building, it was apparent that fears were alleviated. The reality of the situation, although somewhat anxiety arousing, was not as severe as some of the things that had been imagined in the absence of facts. The room remains open and will remain open during renovation to allow access, rehearsal and to allow victims to draw parallels between the room's recovery to full use and individuals' recovery to full physical and emotional health.

Return to School, Faculty and Staff

One of the many unique circumstances in the Cokeville crisis was that faculty and staff were taken hostage and involved in the bombing. Therefore, it was felt that they should be involved in the decision to go back to school. It was also necessary to facilitate their own immediate processing of the trauma. This was accomplished on an ongoing basis from the time of the incident to more informal, small group gatherings on one-to-one exchanges. The Tuesday following the incident was set aside for faculty and staff gatherings as a group. More intensive processing took place at this time. The issue was never whether to return to school or not, but rather what day, and in what exact manner, would this be best accomplished. Primary processing issues with the teachers as a group included, a) what might be expected from the children, b) what might be expected from themselves, c) information on how to handle any exigences, d) provision of adequate levels of support that would enable them to feel comfortable with their perception of what they would be dealing with.

We were aware that in other crises, outside consultants had gone into the classrooms to facilitate children's processing. There were strong concerns about having strangers working directly in classrooms with children in the initial stages characterized by extreme sensitivity to strangers. Therefore, inservice was provided to include specific information to facilitate teacher's continued processing with children in their classes. This included maintenance of the open, supportive atmosphere described earlier. It was accomplished in part by allowing full discussion by the children of the incident, writing in daily journals, and listing on the board of feelings associated with the incident. Artwork, primarily picture drawing, was also encouraged. Because of the close tie that existed between teacher and student, the children had the opportunity of being back in the classroom with someone they were close to and trusted in a new, deeply meaningful way, and permitted a process that would have been difficult to generate in any other way.

Initially, it had been anticipated to return to school by Thursday or Friday. After several meetings, the staff made the decision to return to school for 2 hours on Wednesday, a half-day on Thursday, and to resume a regular schedule on Friday. Support included three to five counselors in the elementary (several of the school psychologists and counselors), and two in the high school where many brothers and sisters had waited throughout the hostage taking. There were also two teachers available and capable of taking over in a classroom in case of need. All backup maintained a visible, but non-intrusive presence. The best news we could have had and did receive was that they were not needed. The worst scenario had to be anticipated, however. Had a child developed unmanageable anxiety and if we had had insufficient support, it would have sent the wrong message to all involved and would have created questions about all individuals and the system's ability to handle the situation.

As children returned to school, it was apparent they needed to rehearse and continue to process the incident. This was allowed to occur unhindered and ran its course in due time—usually ½ to 2 hours. As the routine process of school took hold, many children seemed to benefit from the structure they felt and were reassured by it. There seemed to come a time when the clear message from many was a readiness to get back to some sort of "business as usual" attitude with no more upset than usually is associated with the ending of the school year.

Children

Many children were asking to return to the building Saturday night, May 17th, and many were already also asking when they could return to school. Not to return to school was to send the message that things were so bad that school could not be resumed. To return to school with all due deliberation would establish the expectation that a return to normality was within reach and that those involved were fully capable of managing a resumption of normal activities. The return to school had the effect of putting all parties in the position of being able to say later that they were able to get back to school and resume normalcy in spite of what happened. This was also a valuable time to identify "at risk" children. With this information more focused, follow-up became a real possibility.

Generally, with the passage of time, those children who verbalized most effectively and in the greatest quantity have managed recovery best; and those who returned to school most often have exhibited the fewest symptoms. Therefore, due to these two factors, we have encouraged children seen subsequently to attend summer school. Return to the building has seemed to desensitize children to the facility while staying away has in many cases resulted in development of increased levels of fear.

Summer Follow-up, Victims

Past experience with traumatic crises has indicated that follow-up in some individual cases could go on for 1 to 2 years. When immediate intervention has not been provided, research has suggested the presence of clinical symptoms as long as 4 to 5 years after the incident, (Terr, 1983). Early intervention and follow-up cannot be overestimated as measures calculated to result in a reduction of long term difficulties. Therefore, four counselors have been maintained on a half-time basis during the summer of 1986. Specific follow-up was accomplished through personally delivered survey forms which provided each family an opportunity to seek assistance, acquire information, and to ask questions. Indications (incomplete) to this point would suggest at 15-20% of the victims exhibit reactions acknowledged by parents or identified by others such as teachers, clergy, etc. These have been addressed by the counseling staff on site and the general trend has been a reduction in reactive symptoms and somewhat smaller caseloads. We anticipate continued reduction in the number of children needing follow-up counseling, and efforts will continue to reduce long term reactions. □

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by G. Nohl Sandall, Ph.D.
Afton, WY

Impressions of the Bay Area Quake

by Betty Spicher

Fifteen seconds. The earthquake lasted only fifteen seconds according to the Richter scale. Just a blink on the cosmic timeline, but what a dramatic effect those seconds have had on all our lives!

October 17 was a normal Tuesday in my school. I did some testing, consulted with the principal, talked with a number of teachers about underachieving students, counseled two boys with behavior problems, talked with a parent on the phone and closed the day with a support staff team meeting. Before leaving school I checked my calendar for the coming days and saw that it would be a typical October week in my life as a school psychologist in San Jose, California; nothing that would call for a stretching of skills acquired in the past 15 years as a school psychologist. I headed off to pick up my son and drive to the home of friends for dinner. As we stopped at a red light the car started lurching and heaving. What on earth was happening; was something wrong with the motor? I quickly determined we were experiencing an earthquake; and, being native Californians, we continued on our way.

As Tuesday night progressed into Wednesday morning the scope of the damage began to appear. My school district had little damage; and although nearly all the other districts would be closed on Wednesday, I heard on the T.V. news that we were to be at work. I had not been able to reach relatives in other communities due to power and phone outages; unlike many others I was fortunate that my home had little damage. I was shaken by news reports and worried about aftershocks and about my family. I definitely did not want to have school in session for personal reasons and felt children should be with their parents, most of whom would not be working that day. But, like most school staff I went to work because I felt that if school was open I would be needed there.

We were walking wounded. We had had little sleep. We were startled by every slam of a door, jiggling of a desk, unfamiliar noise or street sound. Eyes were ever vigilant and ears were very alert. We were sure there would be a strong aftershock and we would be responsible for the children in that situation. There were several instances of children, in response to a noise, independently getting under desks and tables in the style of California's "Duck and Cover" preparedness drill. Only about one-third of the students were present that day; it was tension filled and could not end too soon.

I serve two elementary schools and share another with a psychologist who could not make it to work because of road closings. I debated about what to do and where to go as I drove to work. I arrived at one school before classes started and circulated among teachers offering suggestions as to how to help the children deal with their feelings and fears through sharing, drawing and other expressive means. I offered to be "on call" if there were children who seemed exceedingly upset or withdrawn. As classes began I circulated among the classrooms to further offer support to staff. At each school I told the principal and secretaries to call if problems came up. By the time I reached the third school the teachers were gathering students into groups of primary and upper grades as there were so few present and people seemed to need to be together, staff as well as students. I again circulated, talking with each teacher and offering help and support. It seemed to help to know there was backup if needed.

Throughout the remainder of the day I returned to each school to be visibly available. There were several children whom I counseled individually, and in a small special day class I sat with children who were playing with clay as we talked about the earthquake; we shared our experiences and fears and I also provided some factual information about earthquakes. I returned home exhausted, both physically and emotionally; much too tired to do my usual Wednesday aerobics; too tired to pick up the vases, books, and knicknacks that had fallen from the shaking. I did check outside and inside for structural damage and thankfully found none. It was helpful to work through fears and feelings by getting information from T.V. news coverage that went on all evening. I had learned early in the afternoon that my daughter in San Francisco was fine.

On Thursday 85 percent of the students were in attendance and some

semblance of normalcy was returning. Each teacher again gathered the children into a group; and there was sharing about the earthquake. Many teachers also had the children do individual and group drawings to help express feelings. Some teachers had older students do role playing about their experiences in the quake. I circulated among teachers in my schools throughout the day. Teachers seemed to need to talk with me, some took me aside as I went around the building and asked for advice. Interestingly, when discussing problem situations in their personal lives, they occasionally were near tears. Others sought me out to talk about personal problems as well as fears about aftershocks which might occur while they were responsible for children. Some teachers were concerned about colleagues who they felt were near the breaking point; others were angry about the district having school open on Wednesday. The earthquake brought to the surface many raw feelings and coping mechanisms were strained.

At lunchtime many of us informally shared our "where were you when the earthquake struck?" stories and discussed the great damage done to homes of some staff members. The sharing seemed to help. The same afternoon I typed a memo to teachers about helping children deal with the aftermath to disasters and expanding on approaches I had touched on Wednesday morning. I especially wanted them to keep in mind the fact that most children will be experiencing feelings connected with the earthquake for some time; teachers need to watch for those who develop headaches, nausea, anxiety, startling responses, obsessions and problems with concentration. It will be important that they allow time for expression of feelings in the coming weeks. The memo was in their boxes the following morning.

At one of my schools the principal composed a letter to parents and mentioned that the school's psychologist was available to assist with children who were having particular difficulty coping. I returned calls from several parents and offered some suggestions about how they could assist their children. I counseled with four students at that school and talked with their teachers. After I talked with each child I had them draw a picture of something about the earthquake. One girl drew a picture of the ground opening up and swallowing her. In each of the drawings there was intense pencil or crayon pressure and many perserverative lines. I observed that when the children drew those lines they seemed to be very intent and received some satisfaction from the repetition of drawing.

Our group of eight psychologists gathered at a restaurant for lunch on Monday, October 23; and it was therapeutic to share experiences with others about how things were going in our schools. We are a fairly close group and provide good support for one another; how thankful I am for that! That afternoon I had four more calls from worried parents in addition to a parent conference. Almost all of the children and parents report that the children aren't sleeping alone in their beds yet; they are sleeping with a parent; or the whole family is sleeping together in sleeping bags in the living room. It is interesting that most of the parents are calling about male children; it will be interesting to see if this ratio continues, and if so, to speculate as to why males are more referred.

The school staffs were very angry about school being in session on Wednesday and planned to let the administration know their feelings. Perhaps some of this is displaced anger, but with some justification and with a place to focus anger about the earthquake's devastation. I think most of the fallout from this will happen soon and expect to be doing much counseling of parents, teachers, and children.

Now, more than 3,000 aftershocks later, I am exhausted! None of us are sleeping well because we are being wakened by the tremors. I realize I need to take care of myself especially well at this time if I'm going to help others. I walked a couple of miles and went to dinner with my son, who was visiting from out of town. Other than going to aerobics, I kept the rest of my time unstructured. I offered to take donations of clothing from the neighbors on my court to the Salvation Army for those in the disaster areas. It has definitely not been a typical October!

Betty Spicher is a school psychologist in the area around San Jose, California.

Cross-Cultural Issues in Responding to a Tragedy: The Stockton Schoolyard Shootings

by Mike Armstrong

In a scene that must have been reminiscent of past horrors for many Southeast Asians, hundreds of panic-stricken parents rushed onto the Cleveland School campus after hearing that someone had been shooting children there. Like myself, initially they had little or no information about what had happened and were left to their own already scarred imaginations. Like other parents, they too desperately wanted to know if their children were safe. For many, death of loved ones was an all too common experience. We eventually learned that during a morning primary recess a gunman had opened fire on the playground with a semi-automatic AK-47 rifle, killing five, and wounding 29 children and one teacher.

Cleveland is a large K-6 school of approximately 970 students. Seventy percent are Southeast Asian, mostly Cambodian. There are also Vietnamese, Hmong, and Lao children from Southeast Asia. The non-SEA population is a mixture of Hispanic, Black and Caucasian children. The faculty and staff are also mixed ethnically. It was later learned that the murderer had been a student at Cleveland during his primary years when the population of the school was much different.

Initially there was no one to communicate with the crowd. What had happened and what the school was doing with the children was not known. Many of Cleveland's instructional aides are Southeast Asian and bilingual. All were highly involved in caring for wounded and terrified children in the minutes after the shooting. All were too traumatized to be of assistance in communicating with the crowd. As the tension level in the crowd rose, there were periods of near riot. Groups of parents, mostly Southeast Asians, attempted to rush onto the playground where the event had occurred, and they were stopped by police. Thwarted, they then attempted to enter the school building and again were stopped by police. The unavailability of interpreters to communicate with a tense crowd was an immediate cultural issue.

Dealing with the Chaos

Vietnamese, Cambodian, and Hmong-Lao community agencies eventually rushed interpreters to the campus. The school district also rushed bilinguals from across the district to act as interpreters. Along with district personnel, those interpreters helped to reunite children with parents and restore order to the campus. This in itself was problematic. An attempt was made to have parents sign for the children they were taking from the school. Class lists were misplaced in the chaos. Parents who could not read, write, or speak English were asked to sign their names to a list and write the names of children they were claiming. For some families the children acted as interpreters. Workers who had rushed to the campus, speaking only English, could not tell if names were male, female, first or surnames. More confusing was the fact that Cambodian children take their father's surname, and the mother usually retains her family name. A few of the injured children were not identified at hospitals and hence families were not notified for several hours, in part because the children were traumatized and resorted to their native language, but also because their names meant nothing to hospital personnel.

Fears that the shooting was racially motivated ran rampant in the community in the days after the incident. At the same time rumors of a second gunman spread among children, parents, and staff, feeding further fears of a racial conspiracy. Counselors and psychologists dealing with traumatized children and families in the days after the tragedy were often confronted with those issues. While there were circumstances of the shooting that certainly provided some element of believability to those fears and rumors, the police investigation discredited the second gunman which eased tensions somewhat. Racial fears have also calmed, but are still present. Investigation of the murderer, Patrick Purdy, revealed that he did hate Southeast Asians, although many who knew him said that he hated everyone.

The school was reopened the next day. Later in the week a large number of district and volunteer personnel, most bilingual, were transported to the county courthouse where many phones had been installed. Cleveland School families were contacted, encouraged to send their children to school, and informed of the availability of counseling. Rumors or misinformation were corrected. School attendance reached over 80 percent at the end of one week, and was virtually at a normal level after two weeks. Studies of other school tragedies reveal that this return to normal attendance so rapidly in such a complex situation was truly remarkable. After traditional funeral ceremonies and mourning periods, our Southeast Asian students, for the most part, returned to a pattern of normal attendance. Many of our attendance problems were non-Asian students. Families of attendance problem students were typically critical that the Southeast Asian population was being catered to. The truth is that those non-Asian students probably received quantitatively and qualitatively more effective services than Asian families.

How different ethnic groups and different religions view death and handle funerals were issues that school officials and counselors had to learn about quickly. Of the five deceased children, one was Vietnamese-Catholic, two were Cambodian-Buddhist, and two were Cambodian-Protestant. We learned much later that the families of the deceased children were distressed that they were not permitted to view the bodies of their children immediately. Apparently, in their previous society this was the custom. Autopsies were a western tradition, not understood by Southeast Asians. Caskets and burial sights were donated by local funeral parlors and cemeteries. Cremation was the usual way of dealing with bodies of deceased. The families, despite their usual customs, did not want to offend the predominant western culture. The children were buried in local cemeteries in the donated caskets. Not unlike many of us who were in some way affected by the tragedy, the families felt that they had lost control of things that were once theirs alone.

Fear and Suffering

In the following weeks the Southeast Asian children displayed the same PTS (post-traumatic stress) symptoms that other children did: fear, anxiety, numbness, sleep difficulties, eating difficulties, nightmares, clinginess, concentration difficulties, and avoidance of areas associated with the tragedy. Many of the Asian children, however, "suffered in silence," a cultural tradition, more than non-Asians.

Southeast Asian mental health professionals are rare, and Cambodian professionals are practically nonexistent. We located a Southeast Asian mental health agency in Oakland, California, which sent us a team of people one day a week for several weeks. A Chinese-American clinical psychologist who specialized in work with Southeast Asians, and a Cambodian paraprofessional teamed up to provide service. Together they went to homes to interview or evaluate adults or children, and they would talk to classrooms, small groups, or individual

children. The Cambodian paraprofessional would speak to children in Khmer, their dominant language. Children who would not discuss the incident, verbalize, or show any obvious symptoms could hardly keep from talking about it in their own tongue. Many of those children would not express themselves otherwise, even though they spoke adequate English. Some children therefore had little opportunity for healing or therapeutic experiences.

For many of the Southeast Asian children, fears and anxieties had a religious and cultural counterpart. Buddhism, the dominant religion of Southeast Asia, had a strong influence on the culture of the region, even for non-Buddhists. Cambodians, particularly, have a strong belief in spirits and reincarnation that is intricate and difficult for westerners to understand. For children at Cleveland, not fully mature in their own religion or culture, those beliefs were manifested in an intense fear of ghosts, spirits or shadows, particularly of the deceased children and their murderer. During the first week an exorcism was held after school hours on the campus by local religious leaders to rid the site of evil spirits. Weeks later, when the Cambodian children's fear of ghosts reached its height, another more involved and complete exorcism was held on the campus after school hours. Many of the families were bused to this event. For many children, mention that "Banti," a Buddhist monk and local leader, had come to the campus and performed a ceremony to rid it of ghosts was comforting. For many children, telling them of the ceremony was the only thing that counselors could do to comfort them. Counselors learned to use beliefs in ghosts and other spiritual phenomena as meaningful terms or metaphors in therapeutic ways. Through trusting relationships children would explain those beliefs in more detail to therapists, who could then explore culturally relevant ways to cope. Some therapists had difficulty being so creative.

Treatment Approaches

After approximately three months the county mental health system developed a two-pronged effort at healing. One was a full classroom discussion program which dealt with the incident and the children's reactions to it. A therapist, or in some cases therapists, was assigned to each individual classroom in the school to carry out this program. The sessions were for one hour, once a week for five weeks. Teachers were given the choice of having their classrooms participate. All but three teachers accepted. Therapists came primarily from the county mental health system, although there were volunteers and contracted professionals from the private sector and neighboring county mental health system. Artwork, psychodrama, puppet play, lecture and discussion were used as primary vehicles in this effort. Care was taken to include themes, coping strategies and props that were culturally relevant. Classes heavily impacted with Limited English Speaking (LES) children were provided appropriate interpreters. Reactions from teachers suggested that this program was highly successful.

A second approach to treatment was intense group counseling. Injured children, siblings of deceased children, and other highly traumatized children were immediately included in groups. Through the classroom discussion program and with the assistance of school psychologists working at the site, other high priority children were identified and eventually included in groups. When necessary, interpreters were used in the groups. Group counseling was continued throughout the summer at the school site, and at the site of a large apartment complex and adjacent public park where many of our Southeast Asian families lived. Initially, group composition was mixed by gender and ethnicity. For summer counseling, children were prioritized by need, and the number was reduced from more than 300 children to approximately 100.

For new groups, more effort was made to separate groups by gender totally, and somewhat ethnically. While there were some pragmatic reasons for doing this, therapists believed it was also more effective.

Many of the interpreters used were members of the local ethnic communities, and were themselves products of their cultures and victims of their past traumatic histories, just as much as the children and families that they were asked to work with. Many of the therapists became concerned after a period of time that translations were selectively edited or compromised to comply with cultural sanctions or to protect families from shame or embarrassment. While there were numerous clues that this was happening, local professionals familiar with the respective cultures pointed to several cultural values that might be responsible for this: suffering silently, dealing with pain and suffering within families and not sharing family issues in order to avoid or minimize shame on the family, and past experiences with government officials here and overseas where people learned to lie to survive or protect one's self or family.

We learned immediately that fo Southeast Asian adults traumatized b years of war, hardship, and th murderous Pol Pot regime, remember ing would be painful and counter productive. However, children woul need to talk and express their pain. Thi was a contradiction that therapists an children had to deal with. When th Southeast Asian children began to talk they let therapists know that they coul not discuss their fears, sadness or pai with their families. They expressed con cern that discussing such things a school, if discovered, would create pai and embarrassment for their familie and guilt for them. However, as they were afraid, sad, anxious, guilty, or ex periencing other post-traumatic stres symptoms, they needed to talk; and t varying degrees, they did talk.

Conflicts in Understanding

At this point we come to the most central dilemma or conflict in this experience. Southeast Asian families, products of a pre-Freudian society, find western ideas about mental health perplexing. Tragedy, pain or misfortune are viewed as punishment from God for transgressions of ancestors, to be borne silently. They seek comfort in family and friends, and look to the wisdom of religious leaders. Prayer and ritual, along with the company of others, are the only known parallels to western psychological counseling. While Southeast Asians accept the existence of "crazy" individuals, one is either disturbed or not, with nothing in between (i.e. post-traumatic stress). Due to their tradition of herbal medicine, physicians who prescribe medication to alleviate symptoms of pain (e.g., psychological) are tolerated, and adults will take medication or allow children to be medicated. However, Southeast Asians are confused by the differences between psychiatrists who use medication, and psychologists and counselors who do not.

The above mentioned conflicts were evident at a very pragmatic level. Several parent permission forms for counseling and treatment were developed by county mental health personnel, translated, and sent home with children. In the initial version of the translation the term "counseling" was interpreted by parents to mean "intrusion into family affairs." The parents did not return most of the forms; or they returned the forms, refusing permission. A second translation was sent home, along with a district permission for a "field trip." The field trip permission was a legal necessity to allow children to be taken to an adjacent church that had volunteered rooms for counseling. The

two forms together were interpreted as a request to evaluate children for mental disturbance, with possible placement in an institution. The forms were further refined, and interpreters were recruited to make phone calls or home visits to facilitate getting permission. This was finally successful, although I'm not sure that we fully understand the reasons why.

In a bizarre example of how far apart our cultures were, many of the Southeast Asian families were surprised, stressed, and angered by materials sent home prior to March 17th in anticipation of St. Patrick's Day events in classrooms. The *17th* (January) was the date of the shootings and apparently the date that the Khmer Rouge came to rule in Cambodia, thus a bad omen. The killer's name was *Patrick* Purdy, and the families thought that we were somehow honoring or worshipping the murderer of Southeast Asian children on a day that was already symbolic of tragedy. In a situation feared to be racial, and in light of the great deal that was not understood, it is somewhat comprehensible why this happened.

At this point, some nine months after our tragedy, the situation is still unfolding. The news media covered our opening day of school this year and have come at other opportune times. This will continue until our anniversary. A recently released attorney general's report has rekindled the fears of racism. Children are still receiving treatment. Psychologists, counselors and mental health personnel meet once a week to discuss where we are in the treatment of all of our clients, particularly the children. The discussion always goes to the Southeast Asians. One therapist compared our experiences to viewing the movie "Apocalypse Now" – the further the experience goes on, the less clear the rules become. We are still learning, and yet it is not totally clear at this time what we have learned. I know that this experience has caused me to examine what I do, how I do it, what I know or do not know, and who I am. Some therapists believe that the healing will never be complete until we can help the families live better and succeed in our culture.

I hope that this article has been helpful to some of you that may find yourselves working with culturally different populations. I sincerely hope that it will not be in the context of a tragedy even remotely like ours. The story is not complete yet, and I hope that someday we will more fully understand "the rules." Please contact me through *Stockton Unified School District* in Stockton, California, if I can be of any assistance.

I would like to thank the school psychologists of Stockton Unified School District as well as school psychologists and counselors from the following districts, who provided competent and caring assistance to help "my" school get back on its feet: Lodi Unified, Lincoln Unified, and Tracy Unified. The assistance of San Joaquin County Mental Health and other related persons cannot be overlooked. All can be proud.

Mike Armstrong, PhD, is a school psychologist with the Cleveland School, Stockton Unified School District, Stockton, California.

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Disaster Team Works During Crisis

by Gary Alderman

In the early morning hours on September 22, 1989, what has now been called the worst storm of the century came ashore on the South Carolina Coast. Many parts of our state were severely damaged with large numbers of people left homeless and jobless and many of the scenic forests and beaches damaged. The beautiful, historic city of Charleston and the surrounding areas were some of the hardest hit. The Charleston County School District will not soon forget the impact of this storm.

Immediately following the storm, the district formed a Disaster Team to begin the job of developing a plan to deal with the post-traumatic emotional reactions to Hurricane Hugo.

The Disaster Team includes two school psychologists in addition to myself, a special education consultant, two administrative guidance counselors, and two representatives from the local community mental health center.

I was trained as a school psychologist, but now function as an administrator in special education in the Charleston County School District. Like so many of my colleagues, I knew what post-traumatic stress disorder (PTSD) was and, in fact, had been to a couple of sessions concerning PTSD, but the reality of what it meant following Hugo and how to help our students and employees was quite overwhelming.

Our first task as a Disaster Team was to access and coordinate our community resources. Next, we decided that in order to impact on the most students in the short amount of time we had, we needed to train those key people in each of our 70 schools so that they could in turn inservice their respective school faculties in PTSD. Part of our dilemma was not knowing when the students or teachers would return. The community was still in a state of survival and the physical condition of our schools was so poor that uncertainty of when they could be repaired was a constant. Complicating our task further was reaching the 140 support personnel (including 21 school psychologists) that we had decided to train in PTSD. Because so many were displaced and/or without telephones, this was quite a challenge.

Let's stop here and let me point out some important issues surrounding us as we made our plans. Very few people in Charleston were untouched by the storm. Many of us suffered significant damages to our own property and many of those we were slated to train lived on the barrier islands and had still not been able to get to their homes. They were (and some still are) living with others or in hotels. Our school district office building was without electricity and telephones, and while those of us on the Disaster Team made plans, our co-workers cleaned several inches of mud and raw sewage from our building and in our schools. To add to all of this, 25 of our 70 school buildings were severely damaged; many left without roofs and many flooded and smelly. Almost all schools had some significant damage and many materials were destroyed.

Finally, after contacting all of those we intended to contact, two well-known experts in the area from nearby Columbia were asked to consult with our team and conduct the training. The training was held over a period of three hours and included training in the recognition of PTSD signs and a presentation of activities to conduct with students to prevent and intervene with post-traumatic stress disorder. When our teachers returned, two days prior to the return of the students, each of the facilities of the 70 schools received a similar training with a packet of suggested post-Hugo activities. Reports from trainers indicated some crying, some depression, some over- activity, and some anger while training the teachers. Most of all, they noted some relief and thankfulness that they had some idea of how to help students. In one session, which I personally conducted, a teacher cried and shared that this was the first time she had let go of her emotions since Hurricane Hugo hit. Now that the support personnel had inserviced all of the teachers, we were ready for the students.

Our students returned today, the same day I am writing this article, after being out of school for 17 days. Reports from teachers indicate some sadness and depression, some hyperactivity, and some anger (sound familiar?). Most of all, they noted a lot of "normal." Almost all of the students participated in activities designed to help them ventilate and integrate their Hugo experiences. These activities will continue over several months. In addition, a referral process was set up to identify and help those students having the most severe emotional reactions to the storm.

Hurricane Hugo helped us put a lot of things in perspective about life and taught us a lot about how education is quite vulnerable, both physically and emotionally to a disaster. Most importantly, I think it has helped those of us who are charged with the mental health needs of students to put aside re-evaluation deadlines, placement meetings, and other regulatory stipulations. Not to say that these things aren't important, but now is the time to look at our 45,000 students and make sure we can meet their needs in the aftermath of Hurricane Hugo.

I would venture to say that rarely has a community seen the outpouring of goodwill and togetherness that occurred here in Charleston. The schools were no exception. In the weeks before the students returned, school personnel worked in shelters and served in the community in many ways. Then, when it was time for the students to return, educators, facing what seemed to be insurmountable personal and professional odds, met the tasks at hand. As a school psychologist, I was impressed to see how our profession, working closely with other areas, could meet the needs of students and school employees after this trauma. Many administrators, teachers, and other employees of the district have and are looking to us for support and advise on how to help them personally and how to help their students.

Our work is far from over. As we know, post-traumatic stress disorder is significant for long periods of time. This fact will change the role of the school psychologist and others for the rest of this school year and even longer. Hurricane Hugo has changed us all, hopefully making us even better at what we do.

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